ARTICLE I - DEFINITIONS

ANNUAL/SCREENING EXAMS means Coverage is available for a service no sooner than eleven months from the previous service.

BIOLOGIC PRODUCTS are viruses, therapeutic serums, toxins, antitoxins, vaccines, bloods, blood components or derivatives, allergenic products, or analogous products, or arsphenamine or its derivatives (or any other trivalent organic arsenic compounds), applicable to the prevention, treatment or cure of a disease or condition of human beings. Examples of Biologic Products are: vaccines, various toxoids, skin test antigens, allergenic extracts, blood and blood products and certain in vitro test kits intended for testing of Biological Products.

BIOTECH PRODUCTS are Biologic Products manufactured by biotechnology from recombinant, monoclonal or other similar technology, or products containing genes, vectors, plasmids or other genetic components.

CHEMICAL DEPENDENCY/SUBSTANCE ABUSE SERVICES are services and supplies for the diagnosis and treatment of alcoholism and Chemical Dependency disorders which are listed in the Diagnostic and Statistical Manual-IV or any revision thereof. The fact that a disorder is listed in the Diagnostic and Statistical Manual-IV does not mean that treatment of the disorder is Covered under the Group Service Agreement.

COINSURANCE means those amounts which are paid by the Covered Person as a percentage of Eligible Expenses, if applicable. The Coinsurance amounts are applied to Eligible Expenses incurred after any applicable deductible has been met and before any applicable out-of-pocket maximum has been met.

CONTRACT YEAR is the one-year period determined by the Employer Group and the Plan during which benefits are effective and which may not be a calendar year. (For example, if an employer's effective date is July 1st, then the Contract Year is July 1st of that year through June 30th of the following year.)

COPAYMENT means the defined dollar amount the Covered Person is required to pay for certain Health Care Services provided under the Group Service Agreement. The Covered Person is responsible for the payment of any Copayment directly to the provider of the Health Care Services at the time of service.

COSMETIC PROCEDURES are those procedures which improve physical appearance, and do not correct or materially improve a physiological function and are not Medically Necessary.

COVERAGE or **COVERED** is the entitlement by a Covered Person to Health Care Services provided under the Group Service Agreement, subject to the terms, conditions, limitations and exclusions.

COVERED PERSON or **MEMBER** As per ***Agreement for Prepaid Health Care and Administrative Services, January 1, 2003***; *Section V, Eligibility, Enrollment and Effective Date, Sub-Section A* as follows:

A. Eligibility

1. *All active full-time (37½ hours per week) employees and their eligible "dependents".*
2. *All appointed or elected officials and their eligible "dependents".*
3. *Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.*
4. *"Dependent" means:*

a. *Spouse of an employee;*
b. *Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists.*

5. *A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:*
   a. *Is no longer a member of the General Assembly;*
   b. *Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;*
   c. *Who served as a legislator for at least 10 years.*

   A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program. In addition, the surviving spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:
      i. *The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;*
      ii. *The surviving spouse files a written request for insurance coverage with the employer;*
      iii. *The surviving spouse pays an amount equal to the employer's and employee's premium for the group health coverage for an active employee.*

   The eligibility of the retired legislator's spouse, or a surviving spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The spouse's eligibility ends on the earliest of the following:
      a. *When the employer terminates the health coverage program;*
      b. *The date of the spouse's remarriage;*
      c. *When the spouse becomes eligible for Medicare.*
6. *"Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:*
   a. *Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;*
   b. *Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;*
   c. *Must have fifteen (15) years of participation in a retirement fund.*
7. *A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:*
   a. *Retirement date is after June 30, 1990;*
   b. *Will have reached the age of sixty-two (62) on or before retirement date;*
   c. *Is not eligible for Medicare coverage as prescribed by 42 U.S.C 1395 et seq.;*
   d. *Who has at least eight (8) years of service credit as a participant in the judge's retirement fund, with at least eight (8) years of that service credit completed immediately preceding the judge's retirement.*
8. *A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:*

a. *Who is a retired participant under the prosecuting attorneys' retirement fund;*
b. *Whose retirement date is after January 1, 1990;*
c. *Who is at least sixty-two (62) years of age;*
d. *Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and*
e. *Who has at least ten (10) years of service credit as a participant in the prosecuting attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.*

9. *Retirees eligible under subsections 6, 7, or 8 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility ends on the earliest of the following:*
   a. *Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the spouse would be eligible to remain covered until the end of the maximum period under COBRA;*
   b. *When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C 1395 et seq.*
   c. *The end of the month following remarriage; or*
   d. *As otherwise provided in I.C.5-10-8-8 (g).*
10. *Employee on a leave of absence for ninety (90) days or less and out of pay status.*
11. *An employee on family leave.*
12. *An employee on union leave.*
13. *Retirees eligible under IC 5-10-12.*
14. *For legislator, Dependent or spouse as defined and pursuant to the conditions set forth in I.C.5-10-8-8.2.*

CUSTODIAL CARE means non-health related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing, such services and supplies are custodial without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed and without regard to whether they are performed by individuals who are trained or licensed medical or nursing personnel, which include but are not limited to the following: assistance in activities of daily living; transportation; meal preparation; or companion activities.

DURABLE MEDICAL EQUIPMENT is equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury and is appropriate for use in the home, provided however, that such terms shall not include equipment for use in altering air quality or temperature, equipment for use in exercise or training, or equipment that is not normally of use to a person who does not have an injury or disease.

ELIGIBLE DEPENDENT means:

1. Spouse of an employee;

2. Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists.

ELIGIBLE EXPENSES are what the Plan or Network would pay Participating Providers for Health Care Services Covered under the Group Service Agreement (GSA) while the GSA is in effect, except that Eligible Expenses for Emergency and Urgent Care Services provided by non-participating network providers would be equal to the Usual and Customary Charges.

ELIGIBLE PERSON means any person eligible to enroll as a Subscriber under the Agreement as defined by the Group and agreed to by the Plan, and as indicated on the Application for Group Service Agreement and as further described in Article III, Section A.

EMERGENCY SERVICES or **MEDICAL EMERGENCY** means medical services that arise suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

1. Place an individual's health in serious jeopardy;
2. Result in serious impairment to the individual's bodily functions; or
3. Result in serious dysfunction of a bodily organ or part of the individual.

ENROLLMENT means the act of completing an Enrollment Application including designating a Primary Care Physician. A Primary Care Physician must be indicated for each Covered Person in order for the benefits of this Plan to apply to such a Covered Person under this Agreement.

ENROLLMENT APPLICATION means the application for Enrollment in the Plan which must be completed and signed by the Subscriber providing necessary information for the Plan, listing all Eligible Dependent(s) who are to become Covered Persons hereunder on the Individual Effective Date, and, indicating the Covered Person's choice of a Primary Care Physician**.**

EXPERIMENTAL TREATMENT means medical technology or a new application of existing medical technology, including medical procedures, drugs and devices for treating a medical condition, illness or diagnosis that:

1. Is not generally accepted by informed health care professionals in the United States as effective; or
2. Has not been proven by scientific testing or evidence to be effective in treating the medical condition, illness or diagnosis for which its use is proposed.

   See Article VIII for decision-making criteria.

FAMILY means the Subscriber and his or her Covered Eligible Dependents.

FULL-TIME STUDENT means an Eligible Dependent who is enrolled in and attending, full-time, a recognized course of study or training at:

1. An accredited high school or vocational school; or
2. An accredited college or university; or
3. A licensed technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person continues to be a Full-time Student during periods of vacation established by the institution.

GROUP or **EMPLOYER GROUP** is the body of Subscribers eligible for Group insurance by virtue of some common identifying attribute, such as common employment by an employer or a membership in a union, association or other organization.

GROUP SERVICE AGREEMENT means a contract or agreement regarding the benefits, exclusions and other conditions between the Plan (M•Plan, Inc.) and the Group.

HEALTH CARE SERVICES means

1. any services provided by individuals licensed under IC 25-10, IC 25-13, IC 25-14, IC 25-22, IC 25-23, IC 25-26, IC 25-27, IC 25-29, IC 25-33 or IC 25-35.6;
2. services provided as a result of hospitalization;
3. services incidental to the furnishing of services described in subdivision (1) or (2); or
4. any other services of goods furnished for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury.

HOME HEALTH CARE means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization which is primarily engaged in providing skilled nursing service and other therapeutic services in the homes or places of residence of its patients; which has policies, established by a group of professional personnel associated with agency or organization, including one or more Physicians and one or more registered nurses to govern the services which it provides, and provides for the supervision of such services by a Physician or registered professional nurse; and which maintains clinical records of all patients.

HOSPICE CARE means a program designated to provide care for the terminally ill who have a medical prognosis of a life expectancy of six months or less, through a Medicare approved Hospice program. Hospice Care must be directed by professional medical personnel licensed within the state in which they practice. The treatment is intended to enhance comfort and improve the quality of the patient's life and emphasizes pain and symptom control rather than curative care for terminally ill patients in the final weeks and months of a patient's life.

HOSPITAL means an acute general Hospital which provides inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of one or more duly licensed Physicians; which provides continuous nursing service by or under the supervision of registered professional nurses; and is not a federal Hospital nor a place for the aged, nor a Skilled Nursing Facility, nor a nursing home, nor an institution of rehabilitation; and which is an institution which operates as an acute general Hospital pursuant to applicable state or federal laws.

HOSPITAL INPATIENT means a Member formally admitted to a Hospital as ordered by a Physician or other individual authorized by the state licensure law and Hospital staff bylaws, and to whom a bed and board charge will apply.

IMMEDIATE CARE/URGENT CARE CENTER is a facility that provides Coverage for Covered Persons who are referred for Immediate Care/Urgent Care Services by their Primary Care Physician.

IMMEDIATE CARE/URGENT CARE SERVICES means medical care for an unforeseen illness or injury that is not life threatening but requires prompt evaluation.

INDIVIDUAL EFFECTIVE DATE is the date stated on the Subscriber Enrollment Application, except that the Individual Effective Date for any other Covered Person is the date that the Covered Person became eligible as an Eligible Dependent of the Subscriber, but only if an Enrollment Application listing the Eligible Dependent is submitted to the Plan within thirty (30) days of eligibility, and the appropriate Rate is paid commencing with said date. A newborn child or an adopted child of a Subscriber or a

Subscriber's eligible spouse is automatically Covered for the first thirty (30) days. Subscribers with full family Coverage currently in effect may enroll newborn dependents after the thirty (30) day period from date of birth.

INHERITED METABOLIC DISEASE means a disease caused by inborn errors of amino acid, organic acid or urea cycle metabolism and is treatable by the dietary restriction of one (1) or more amino acids.

INITIAL ELIGIBILITY PERIOD is the period of time, determined by the Group, during which Eligible Persons may enroll themselves and Eligible Dependents under the Group Service Agreement.

INPATIENT HOSPITAL SERVICES means the Medically Necessary services and supplies furnished to a Member who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services. Typical Inpatient Hospital Services include bed and board (room and board), nursing services, use of Hospital facilities, drugs, Biologic Products and Biotech Products, supplies, appliances and equipment, and any other diagnostic or therapeutic items or services ordinarily furnished to inpatients.

MEDICAL NECESSITY or **MEDICALLY NECESSARY** means services and/or supplies provided by a Hospital, Physician, or other Health Care Services provider to identify and treat an illness or injury that are:

1. consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury;
2. appropriate with regard to standards of good medical practice; and
3. not primarily for the convenience of the patient, the patient's family, the Physician or the Provider.

MEMBERSHIP CARD means the document of identification issued by the Plan.

MORBID OBESITY means:

1. a weight of at least two (2) times the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables; and
2. a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
3. a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

NETWORK is a defined group of Participating Providers, linked through contractual arrangements to each Network, which supply a full range of Health Care Services. The Network contracts with the Plan to provide services to Covered Persons who have selected the Network for the provision and coordination of all Health Care Services Covered under the Group Service Agreement. A Network does not include all of the Plan's Participating Providers.

1. In-Network means the Covered Person receives Health Care Services from his/her specific Network's Participating Providers, such as Primary Care Physicians, Specialty Physicians, Hospital(s), laboratories or Urgent Care Centers.
2. Out-of-Network means the Covered Person utilizes a provider or facility that is not contracted with his/her Network. For Urgent and Emergency Services, please see Article IV, Schedule of Benefits.

OBSERVATION STAY are those services furnished on a Hospital's premises, including use of a bed and periodic monitoring by a Hospital's nursing or other staff to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital as an inpatient as ordered by a Physician or other individual authorized by state licensure law and Hospital bylaws.

OPEN ENROLLMENT PERIOD means the period of time established by the Group, during which Eligible Persons who have not previously enrolled with the Plan may do so and during which Subscribers

can make eligible changes.

ORTHOTIC means a device defined as an orthopedic appliance or brace; a rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

OUT-OF-POCKET MAXIMUM means the maximum Copayment and Coinsurance amount, per Covered Person per Contract Year. The Out-of-Pocket Maximum does not include Copayments or Coinsurance for Prescription Drugs (including Biotech Products and Injectable Drugs) and Diabetic Drugs and Supplies.

OUTPATIENT SERVICES means those institutional services rendered to a Covered Person who is not a bed patient in a Hospital or Skilled Nursing Facility at the time services are rendered.

PARTICIPATING PHYSICIAN means a Participating Provider (Physician) who has entered into an agreement with the Plan or with another organization that has an agreement with the Plan to render services to Covered Persons under this Agreement. A directory of Participating Physicians available under this Agreement will be published from time to time by the Plan for use by Subscribers.

PARTICIPATING PROVIDER means a Physician, Specialty Physician, Hospital, laboratories, Health Care Services provider or other institution or service independent of the Plan who/which has entered into an agreement with the Plan or with another organization, which has an agreement with the Plan to render services to Covered Persons under this Agreement.

PERVASIVE DEVELOPMENTAL DISORDERS as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association includes, but is not limited to, Asperger's syndrome or autism.

PHARMACY DEFINITIONS:
When Pharmacy Coverage is selected by the Employer Group, Pharmacy Definitions pertain to Diabetic Drugs and Supplies, Family Planning Prescription Drugs, Prescription Drugs and Supplies and Self-Administered Prescription Drugs in Article IV, Schedule of Benefits.

1. **Pharmacy Program** means the Plan program that establishes, updates and maintains the Plan's Pharmacy benefit. This program includes the programs, policies, medication lists, procedures and guidelines of the Pharmacy and Therapeutics Committee.
2. **Pharmacy & Therapeutics Committee** means the selected group of Plan Physicians from the various Networks, the Plan Medical Director, Plan Pharmacy Director, Plan Clinical Pharmacists, Plan Pharmacy Operations Manager and a Plan Nurse that meet to review and update the Plan's Pharmacy Program.
3. **Pharmacy** means any facility, department or other place that has been issued appropriate state and/or federal licenses where prescriptions are filled or compounded and are sold, dispensed, offered or displayed for sale and which has as its principal purpose the dispensing of drugs and health supplies intended for the general health, welfare and safety of the public, without placing any other activity on a more important level than the practice of Pharmacy.
4. **Participating Pharmacy** means a Pharmacy independent of the Plan, which has entered into an agreement with the Plan, or with another organization that has an agreement with the Plan to render services to Covered Persons under this Agreement.
5. **Diabetic Drugs and Supplies** means the prescription drugs or supplies necessary for the treatment of Diabetes, such as insulin or test strips.
6. **Over-the-Counter (OTC) Select Drugs** mean those OTC drugs which offer additional value over comparable OTC drugs as determined by the Pharmacy and Therapeutics Committee.

7. **Generic Equivalent Drug** refers to those prescription drugs whose brand name counterparts are no longer under patent protection. Generic Equivalent Drugs must contain the same active ingredients as their brand name counterparts and must be identical in strength, dosage form and route of administration. Generic drugs must also supply the same amount of the active ingredient in the body, at the same rate, as the brand name drug. Generic Equivalent Drugs can be marketed only after the product and its manufacturer has been approved by the Food and Drug Administration (FDA). This requires that Generic Equivalent Drugs be produced in accordance with stringent government regulations called current Good Manufacturing Practices (GMP).
8. **Generic One Drugs (Formulary Generic)** mean those prescription drugs that the Plan has included on its Generic One list or has been so placed by the Pharmacy and Therapeutics Committee. The separation of Generic drugs into Generic One and Generic Two drugs is not applicable to all plans.
9. **Generic Two Drugs (Non-Formulary Generic)** mean those prescription drugs that the Plan has not included on its Generic One list or have been so placed by the Pharmacy and Therapeutics Committee. The separation of Generic drugs into Generic One and Generic Two drugs is not applicable to all plans.
10. **Select Brand Name Drugs (Formulary Brand)** mean those brand name prescription drugs which the Plan has included on its Select brand name list or have been so placed by the Pharmacy and Therapeutics Committee.
11. **Non-Interchangeable Brand Name Drugs** mean brand name prescription drugs for which a Generic drug is available, but the Plan has deemed that the Generic substitute may be less acceptable. The Non-interchangeable Brand Name drug is therefore dispensed at the Generic Copayment level.
12. **Non-Select Brand Name Drugs (Non-Formulary Brand)** mean those prescription brand name drugs which the Plan has not included on its Select brand name list or have been so placed by the Pharmacy and Therapeutics Committee.
13. **Maintenance Prescription Drugs** mean drugs that meet the following criteria:
    a. The drug's most common use is to treat a chronic disease state when a therapeutic endpoint cannot be determined. Therapy with the drug is not considered curative.
    b. The drug is administered continuously rather than intermittently ("PRN" or "as needed") and longer than ninety (90) days.
    c. The drug has low probability for dosage or therapy changes due to side effects, serum concentration monitoring, or therapeutic response over a course of prolonged therapy.
    d. The drugs' main indication and use is limited to typical outpatient use of a drug. A drug may have an indication for maintenance therapy but lacks the Maintenance Drug Code if that indication is not the most common.
    e. Drug dosage forms that are not practical for large dispensing quantities (such as liquids) or have limited expiration dating, or are limited by controlled substance status may not be on the list.
    f. The Plan assigns an electronic flag to drugs that meet the above criteria. This electronic flag is called the Maintenance Drug Code. The Maintenance Drug Code determines if a drug is on the Maintenance Drug List. This list is maintained by the Plan and updated regularly, and includes drugs such as hormone replacement therapy, blood pressure drugs and antidepressant drugs.
14. **State Restricted Drugs** mean non-federal legend drugs that are restricted to prescription order by state law.
15. **Self-Administered, Injectable Prescription Drug** means a drug that is typically administered by intramuscular or subcutaneous injection and is used to treat a chronic condition for which the patient is expected to manage his/her own care on a daily/frequent basis.

PHYSICIAN means a practitioner of the healing arts holding an unlimited license in the State of Indiana for the practice of medicine or osteopathy, practicing within the scope of his or her license.

PHYSICIAN SERVICES are professional or medical services rendered by a Physician when reasonable

and Medically Necessary for the diagnosis or treatment of a condition, disease or ailment.

PLAN means M•Plan, Inc.

PRIMARY CARE PHYSICIAN means a Participating Physician who has agreed to assume primary responsibility for the medical care of a Subscriber or Eligible Dependent under the Plan (e.g. family practitioner, general practitioner, pediatrician, internist or obstetrician for maternity care).

PRIOR AUTHORIZATION means the process of obtaining Coverage approval by the Plan before receiving a service or medication.

PROSTHETIC means a device defined as a fabricated, reusable, external, removable substitute for a diseased or missing part of the body.

RATE means the amount currently charged by the Plan for all benefits and services Covered under the Agreement.

RECONSTRUCTIVE SURGERY is performed on abnormal structures of the body caused by birth defects, developmental abnormalities, trauma, infection, tumors or disease.

REFERRAL PHYSICIAN means a Participating Physician who has entered into an agreement with the Plan or with another organization that has an agreement with the Plan, or has been approved by the Plan to render services to Covered Persons under this Agreement.

RESPITE CARE means short-term inpatient or outpatient care to give a caregiver relief from the physical demand and emotional stress of caring for the hospice patient. Inpatient Respite Care means a short-term admission to a participating Hospital, hospice facility or nursing home to give a caregiver relief from the physical demands and emotional stress of caring for the patient. Outpatient Respite Care means outpatient care to give caregiver relief from the physical demands and emotional stress of caring for the patient.

RIDER is additional medical Coverage purchased by the Group in addition to basic Health Care Services Covered under the Group Service Agreement. Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when approved by the Plan.

SEMI-PRIVATE ACCOMMODATIONS is a room with two (2) or more beds. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available.

SERVICE AREA means the Indiana counties in which the Plan is authorized by the Indiana Department of Insurance to conduct business.

SKILLED NURSING FACILITY means an institution or a distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care and has one or more Physicians and one or more registered professional nurses responsible for the care of said patient; has a requirement that every patient must be under the supervision of a Physician; maintains clinical records on all patients; provides twenty-four (24) hours nursing services; provides appropriate methods and procedures for the dispensing and administration of drugs and Biologic Products and Biotech Products, and is duly licensed by the appropriate governmental authorities, if any, except the term "Skilled Nursing Facility" does not include any institutions or portions of any institutions which are exclusively for

custodial or domiciliary care or for the care and treatment of mental diseases.

SPECIALTY PHYSICIAN means a Participating Physician who is not a Primary Care Physician who has entered into an agreement with the Plan or with another organization who has an agreement with the Plan, or has been approved by the Plan to render services to Covered Persons under this Agreement.

STABILIZED means to provide medical treatment to an individual in an Emergency as may be necessary to assure, with reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

1. The discharge of the individual from an Emergency department or other care setting where Emergency Services are provided to the individual.
2. The transfer of the individual from an Emergency department or other care setting where Emergency Services are provided to the individual to another health care facility.
3. The transfer of the individual from a Hospital Emergency department or other Hospital care setting where Emergency Services are provided to the individual to the Hospital's inpatient setting.

SUBSCRIBER means the Eligible Person who has applied for Enrollment in the Plan to receive medical services.

SURGICAL SERVICES means the performance of surgical procedures by a health professional that may be legally rendered by such person.

URGENT CARE/IMMEDIATE CARE SERVICES means medical care for an unforeseen illness or injury that is not life threatening but requires prompt evaluation.

USUAL AND CUSTOMARY CHARGES are fees for Covered Health Care Services and supplies which, in the Plan's judgment, are representative of the average and prevailing charge for the same Health Service in the same or similar geographic communities where the Health Care Services are rendered and which do not exceed the fees that the provider would charge any other payor for the same services.

ARTICLE II - GROUP EFFECTIVE DATE, PAYMENT OF RATES, TERMINATION OF AGREEMENT

A. A Membership Card will be issued to the Subscriber and spouse (if eligible) with pertinent information concerning the Member's coverage, expiration date and identification number. This card must be used to indicate coverage under the Plan. The Membership Card is the property of M•Plan, Inc. The Covered Person is responsible for any charges incurred after a Covered Person is terminated.

B. Notwithstanding anything in this Article II to the contrary, the Plan shall continue to provide the benefits and services of the Agreement to the Subscribers and Covered Persons during the grace period, and the Group shall be liable for payment of Rates for such Subscribers and Covered Persons during such period.

C. In the event of termination of this Agreement by the Group or the Plan, all entitlement to benefits for all persons covered hereunder as Covered Persons shall terminate as of the effective date of termination of this Agreement and this Agreement shall be of no further force or effect.

ARTICLE III - ENROLLMENT, INDIVIDUAL EFFECTIVE DATE, TERMINATION OF COVERAGE, CONTINUATION OF COVERAGE

A. All Eligible Persons desiring to enroll in the Plan are required to complete and sign a Subscriber Enrollment Application unless an alternative method of enrollment is agreed to by the Plan and the Group. Eligible Persons must maintain a permanent residence within the approved Service Area. Each Eligible Person must select a Network of Participating Providers and within that Network, designate a Primary Care Physician whose office is located within fifty (50) miles of where the Eligible Person lives. And further, for each Covered Person, designate a Primary Care Physician within the Eligible Person's Network. Please see Article I, Definitions for Network. The Primary Care Physician will coordinate, supervise and provide ongoing medical care to the Covered Person with the Network's participating specialists and Hospitals. (See also Article III, Section H.)

   An Eligible Person and/or their Eligible Dependents may change Primary Care Physicians within the same Network every ninety (90) days, but no more frequently than twice yearly. An Eligible Person may change Networks only during an Open Enrollment period except when the Eligible Person moves more that fifty (50) miles from their PCP.

   If an Eligible Person commits fraud or misrepresents the facts when completing the Subscriber Enrollment Application or approved substitute, Coverage will be terminated retroactive to the date of initial Enrollment.

B. If a Subscriber changes Coverage under this Agreement from Subscriber only to Subscriber and Eligible Dependent(s) Coverage due to the new addition of the Eligible Dependent(s) as defined in Article I, Covered Person and Eligible Dependents, hereof, such Eligible Dependent(s) Coverage shall commence
   on the date of the addition of the Eligible Dependent(s), if such request and payment of the appropriate Rate are received within thirty (30) days following such addition.

C. Eligible Persons whose Enrollment Applications are received by the Plan shall have their Coverage hereunder become effective at twelve (12) midnight coincident with the date of eligibility established by the Group and approved by the Plan for health Coverage.

D. No Covered Person shall have his/her coverage terminated under this provision because of the amount, variety or cost of the services required by such Covered Person. The coverage of any Covered Person shall terminate:
   1. As provided in Agreement for Prepaid Health Care and Administrative Services.
   2. At twelve (12) midnight the last day a Covered Person qualified as a Covered Person as a result of termination of coverage by the Plan with notice for just cause including but not limited to: submission of fraudulent claims, refusal to follow a Plan Physician's treatment plan (subject to Grievance Procedure ruling if Covered Person requests), gross or repeated misbehavior including but not limited to abusive behavior towards health Providers or administrative staff in applying for or seeking any benefits under this contract, failure to pay any required copayments or deductible amounts which are the responsibility of the enrollee and the misuse of any Member materials as set forth in Article X, Section E of this Agreement.

   No Covered Person shall be disenrolled under the provisions of Article III, D, 2, unless prior thereto he/she has been given written notice thirty (30) days in advance of this disenrollment. Such notice

shall specify the reason or reasons for disenrollment and shall inform the Covered Person of his/her right to appeal the disenrollment.

E. Continuation of Coverage For Inpatients Upon Contract Termination By the Plan
If the contract is terminated by the Plan, a Member who is hospitalized for a medical or surgical condition on the date of termination will have continuation of Coverage for inpatient services for up to sixty (60) days. The continuation of Coverage is not required if one of the following occurs:
1. The Member is discharged from the Hospital;
2. Sixty (60) days pass after contract termination;
3. The hospitalized Member obtains from another carrier Coverage that includes the Coverage provided by the Plan;
4. The Group terminates the contract; or
5. The Plan terminates the Member's Coverage due to:
   a. The Member knowingly provides false information to the Plan;
   b. The Member's failure to comply with the rules of the Plan as stated in the contract;
   c. The Member's failure to pay a premium within the grace period permitted under the Group Service Agreement.

F. Continuation of Coverage
The Group Service Agreement between the Group and the Plan incorporates the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) which provisions do not apply to the Group if it normally employed fewer than twenty (20) employees on at least 50% of its typical business days during that particular calendar year, or as may be determined by applicable statutes or governmental regulations. Only common law employees are taken into account for purposes of the small employer plan exception; self-employed individuals, independent contractors and directors are not counted.

COBRA generally requires certain employers who sponsor health plans to offer continuation of health care Coverage to employees who lose Coverage because of reduction in hours of work or whose jobs terminate and to their qualified Eligible Dependents in specific circumstances.

There are specific circumstances for qualifying for this Coverage. Employers and plan administrators are responsible for advising employees and qualifying Eligible Dependents of this Coverage in order to comply with COBRA.

G. Special Enrollment of Eligible Individuals/Coverage Limitations for Members Who Reside Outside the Service Area
Eligible employees or the Eligible Dependents of eligible employees who lose other health care Coverage are permitted to enroll in the Plan if the Eligible Person requested Enrollment in the Plan within thirty (30) days of the loss of their Coverage, and if each of the following conditions are met:
1. The employee or Eligible Dependent was already Covered under other health care Coverage when the Plan was previously offered;
2. The employee or Eligible Dependent declined Coverage in the Plan because the employee had another source of Coverage;
3. The employee or Eligible Dependent exhausted his or her COBRA continuation Coverage or the individual's Coverage terminated because of a loss of eligibility for Coverage (due to legal separation, divorce, death, termination of employment or reduction in hours of employment) or termination of employer contributions towards Coverage.

An adopted child of a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty (30) days from the earlier of:

1. The date of placement for the purpose of adoption; or
2. The date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption and continues for thirty (30) days unless the placement is disrupted prior to legal adoption and the child is removed from placement.

For Coverage beyond the first thirty (30) days, an Enrollment Application must be filed with the Plan and applicable premiums paid within the thirty (30) day period described above.

A child born to a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty (30) days from date of birth. For Coverage beyond the first thirty (30) days, an Enrollment Application must be filed with the Plan and applicable premiums paid within the first thirty (30) days from the date of birth. Subscribers with full family Coverage currently in effect may enroll newborn dependents after the thirty (30) day period from date of birth.

If an Eligible Dependent child is:

1. incapable of self-sustaining employment by reason of being mentally or physically disabled; and
2. chiefly dependent upon the Subscriber for support and maintenance at the time he or she reaches the specified age, then such Eligible Dependent child shall remain an Eligible Dependent child for the duration of such disability and dependency.
3. a Dependent child of the Subscriber or spouse who attained the limiting age while Covered under another health care policy meets the criteria specified above, said Dependent child is an Eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability as described below will be required.

The Plan may require proof of the person's disability and/or dependency be furnished to the Plan by the Subscriber within one-hundred twenty (120) days of the child's attainment of the limiting age and subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The Plan may require proof once per year in the time more than two (2) years after the child's attainment of the limiting age.

An eligible employee who a court has ordered through a qualified support order that health Coverage be provided for a spouse or a minor or Eligible Dependent child of an eligible employee may enroll these Eligible Dependents in the Plan outside of open enrollment.

An Eligible Person must select a Primary Care Physician for each Covered Eligible Dependent within the Eligible Person's Network of Participating Providers. The Primary Care Physician will coordinate, supervise and provide ongoing medical care to Covered Persons with the Network's participating specialists and Hospitals.

Eligible Dependents or COBRA eligibles who reside outside the Service Area have Coverage only for Urgent or Emergent Care and must utilize their Network's Participating Providers for all other medical care services.

I. Family and Medical Leaves of Absence

A Covered Person who is on an approved leave under the Family and Medical Leave Act of 1993 (FMLA), as it may be amended from time to time, may continue participation in the Plan commensurate with the type of Coverage in effect on the day immediately before the leave begins by continuing to pay the required employee contribution.

FMLA continuation of Coverage will continue until the first of the following to occur:

1. The employee's return to active employment with the employer; or
2. The end of the twelve (12) week FMLA leave period. In the event a Member does not return to

active employment at the end of the twelve (12) week FMLA leave period, Coverage under the Plan may be continued under COBRA, with the COBRA period measured from the date FMLA leave ends.

J. Military Service Leaves of Absence
If a Member is absent from work due to military service, the employee may elect to continue participation in the Plan commensurate with the type of Coverage in effect on the day immediately prior to the start of leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as it may be amended from time to time. Coverage will continue until the earlier to occur (a) the date the employee fails to return to active employment as required under USERRA, or (b) eighteen (18) months. In order to continue Coverage, the employee must continue to pay the required contribution under the Plan during the first thirty (30) days of leave. Thereafter, the employee is required to pay a premium in the same amount as that required under COBRA.

K. Certification of Creditable Coverage
Plan shall provide each Eligible Person, Eligible Dependent or COBRA beneficiary who is a Plan participant with a written statement showing the period of Coverage as a Plan participant at each of the following times:

1. When the participant ceases to be a Covered Person.
2. When the participant ceases to be an Eligible Person or Eligible Dependent.
3. Upon a COBRA beneficiaries cessation of COBRA Coverage; and
4. Upon request by a former Plan participant at any time within two (2) years after the later of the date such person ceases to be a Covered Person or the date such person ceases to be a COBRA beneficiary.

ARTICLE IV - SCHEDULE OF BENEFITS

Unless otherwise specifically stated to the contrary, the benefits and services described are Covered services only if and to the extent that the services are:
1. Medically Necessary, and
2. Prescribed, provided or referred by the Member's Primary Care Physician , and
3. Prior Authorized in accordance with the Plan's policies and procedures.

Covered services are available only from Participating Providers unless:
1. Prior Authorized by the Medical Director of the Plan or his designee, or
2. Such services are Emergency Services or Urgent Care Services when the Covered Person is beyond a fifty (50) mile radius of his/her Primary Care Physician's office.

Neither the Plan nor its Participating Providers have any liability or obligation for any service or benefit sought or received by any Member from any other Physician, Hospital or other person, institution or organization.

Participating Providers are not authorized to speak on behalf of the Plan as to what is a Covered service. Therefore, actions or statements by Participating Providers, which are inconsistent with these requirements, will not be considered a waiver of these requirements. Failure to obtain Prior Authorization from the Medical Director of the Plan, or his designee, when Prior Authorization is required will result in denial of Coverage.

Some Covered services may require Copayments or Coinsurance to be made by the Member to the provider of services.

Out-of-Pocket Maximum - This is the maximum Copayment and Coinsurance amount of two thousand ($2,000) dollars that a Covered Person is responsible for per Covered Person per Contract Year. The Out-of-Pocket Maximum for a Family is met when two (2) or more Covered Persons in the Family have each met their individual Out-of-Pocket Maximum. Each family has an Out-of-Pocket Maximum of four thousand ($4,000) dollars. The Out-of-Pocket Maximum does not include Copayments or Coinsurance for Prescription Drugs (including Biotech Products and Injectable Drugs) and Diabetic Drugs and Supplies.

Lifetime Maximum for this Group Service Agreement is one million ($1,000,000) dollars per Covered Person (excluding Transplant Services -There is a separate lifetime maximum for Transplant Services).

Please reference Article I, Definitions and Article V, General Exclusions and Limitations, for exclusions *in addition* to those listed with the benefits in this Article.

Ambulance Service	**Copayment/Coinsurance Required**
	$50 per transport

Ambulance services to a Hospital when requested by a Participating Physician are Covered. A Participating Physician's prescription or referral is not required if ambulance services are used in an emergency situation. The Plan will review all non-authorized ambulance services to determine the Medical Necessity for ambulance services. (Unnecessary or unauthorized ambulance service is not a Covered benefit). Air ambulance services require the Plan's Prior Authorization unless rendered in

an emergency. Only ground transportation ambulance services will be approved unless air ambulance services are required for Member safety.

Exclusions

1. Non-emergency ambulance services or ambulance services not authorized by a Primary Care Physician or the Plan's Medical Director.
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Biotech Products/Injectable Drugs	**Copayment/Coinsurance Required**
Outpatient:	20% of Eligible Expenses
Inpatient:	No Charge

To be Covered, a Biotech Product must be

1. Medically Necessary, and
2. The Food & Drug Administration (FDA) approved for the particular condition being treated. If the Biotech Product has not been approved by FDA for the particular indication being treated, it is Covered:
   a. According to the Plan's benefit interpretation guidelines and limitations if applicable, or
   b. The Biotech Product is recognized for the treatment of a particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted), or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a ψ and not experimental discussion) or,
   c. The Biotech Product is demonstrated for a particular condition/type of cancer to be safe and effective in at least two (2) formal clinical studies, the results of which have been published in peer reviewed professional medical journals published in the United States, Great Britain, Canada or Australia.
3. See Article IV, Hospital Services.

Exclusions

1. Biotech Products not approved by the FDA or not indicated for the particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted) or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a □ and not experimental discussion), except as stated above under "Covered".
2. Allergy Serum/Extracts
3. Infertility Biotech Product drugs (See Article IV, Family Planning Prescription Drugs)
4. Insulin (See Article IV, Diabetic Drugs and Diabetic Supplies)
5. Immunizations, vaccinations or inoculations or allergy testing (See Article IV, Physician Services)
6. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Chemical Dependency and Substance Abuse Services - Inpatient And Outpatient	**Copayment/Coinsurance Required**

Substance Abuse Services or Chemical Dependency Services for diagnosis/short-term evaluation or crisis intervention and detoxification.

Inpatient Elective detoxification means medically supervised withdrawal from addictive substances performed in an inpatient substance abuse setting	Same Copayment/Coinsurance as Inpatient Hospital Services
Outpatient Elective detoxification means medically supervised withdrawal from addictive substances performed in an outpatient substance abuse setting	Same Copayment/Coinsurance as specialty office visit Copayment

Substance Abuse or Chemical Dependency Services; Intensive Outpatient Program Services.

Exclusions

1. Experimental/medical psychiatric procedures, pharmacological regimens and associated Health Care Services, and/or those services or procedures that are not consistent with accepted standard medical practice, or services requiring approval by any governmental authority prior to use where such approval has not been granted or services not approved for Coverage by Medicare
2. Inpatient rehabilitation of chronic alcoholism or drug addiction or abuse. Services for alcoholism, drug abuse and addiction shall be limited to diagnosis, evaluation and treatment for detoxification
3. Substance Abuse or chemical dependency therapy on court order or as a condition of parole, unless treatment otherwise would be Covered
4. Coverage for Custodial Care, nursing home care, Respite Care, rest cures and domiciliary care, regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including services in group homes, halfway houses or residential facilities
5. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Dental Services - Emergency	**Copayment/Coinsurance Required**
	Subject to applicable Copayment/Coinsurance

1. Emergency care required to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth when provided within twenty-four (24) hours of the injury.
2. Re-implantation of natural teeth within twenty-four (24) hours of loss due to accidental injury.

Exclusions

1. Injury resulting from mastication
2. Dental services, surgery, treatment or care, or dental x-rays, supplies and associated expenses (including hospitalization, except for those services described above.)
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Diabetic Drugs and Diabetic Supplies	**Copayment/Coinsurance Required**

The Member pays the lesser of the Copayment/Coinsurance or the Pharmacy's Usual and Customary charge for up to a thirty (30) day supply, which should not exceed a manufacturer's standard packaging unless Medically Necessary. Examples of a manufacturer's standard packaging include but are not limited to, a vial of insulin, a package of test strips or a box of disposable syringes.

Reference Article I, Definitions for Pharmacy Definitions and Article IV, Schedule of Benefits for Prescription Drugs for Coverage and Limitations.

In lieu of brand name drugs/supplies, Generic Equivalent Drugs/supplies will be dispensed when substitution is permissible.

Formulary Generic and Non-interchangeable Brand Name Drugs	$10
Formulary Brand Name Drugs	$20
Non-Formulary Brand Name or Non-Formulary Generic Drugs	40% of Eligible Expenses ($40 minimum, $100 Maximum)
Mail Order Prescription Drugs	A ninety (90) day supply of Prescription Drugs is available for two (2) thirty (30) days supply Copayment(s). Copayments by tiers listed below apply to Mail Order Pharmacy.
Formulary Generic and Non-interchangeable Brand Name Drugs	$20
Formulary Brand Name Drugs	$40
Non-Formulary Brand Name or Non-Formulary Generic Drugs	40% of Eligible Expenses ($80 minimum, $150 Maximum)

Exclusions

1. Diabetic drugs not approved by the FDA or not indicated for the particular condition in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted) or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a and not experimental

discussion), except as stated above under "Covered"
2. DME (Durable Medical Equipment) as defined by the Plan such as external ambulatory insulin pumps and related components (See Article IV, Durable Medical Equipment)
3. OTC (Over-The-Counter) non-prescription Diabetic Drugs and Supplies, except those defined by the Pharmacy Program
4. State restricted Diabetic Drugs
5. Any diabetic drug labeled, "Caution-Limited by Federal law to Investigational Use" or experimental drugs even though a charge is made to the patient
6. Take home diabetic drugs and/or supplies from the Hospital
7. Convenience items, including unit of use packaging for patient convenience
8. Diabetic drugs in unit dose packaging for institutional use
9. Non-self administered injectable diabetic drugs as defined by the Pharmacy Program
10. Extra Diabetic Drugs and/or Supplies for vacation, travel or to replace those that have been lost
11. Biotech Diabetic Drugs, except insulin (See Article IV, Biologic Products)
12. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Dialysis **Copayment/Coinsurance Required**

$20 per treatment

Services and supplies per the Plan's specifications for both acute and chronic dialysis. If Covered by Medicare, see Article IX, Section L.

Exclusions
Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Durable Medical Equipment **Copayment/Coinsurance Required**

20% of Eligible Expenses

Durable Medical Equipment and related components are Covered when Medically Necessary and authorized in accordance with the Plan's precertification process and included on the Durable Medical Equipment list.

Exclusions
1. Convenience items as defined by the Plan
2. Air conditioners, air filters, heaters, humidifiers and other equipment that adjusts or regulates the interior environment
3. Equipment for use in exercising or training
4. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Emergency Services **Copayment/Coinsurance Required**

$75 per emergency room visit

The applicable Emergency Services Copayment or Coinsurance will be waived in the event the visit results in the Member being admitted as a Hospital Inpatient. Any applicable Inpatient Copayment will

apply at that point. Any applicable Copayment/Coinsurance will not be waived for an Observation Stay.

1. Emergency Services are Covered for care obtained in an emergency by a Covered Person without:
   a. Prior Authorization; or
   b. Regard to the contractual relationship between:
      i. The Provider who provided Health Care Services to the Covered Person in an emergency; and
      ii. The health organization;
      In a situation where a prudent lay person could reasonably believe that the Covered Person's condition required immediate medical attention. The emergency care obtained by a Covered Person includes care for the alleviation of severe pain, which is a symptom of an emergency.
2. If Emergency Services are received from an Out-of-Network Provider, the Plan must be notified within forty-eight (48) hours of the start of such emergency care or as soon as reasonably possible thereafter. The Plan may, at its sole option, elect to transfer the patient at its expense to the care of a Participating Provider, subject to the condition that such transfer not jeopardize the Member's health.
3. All claims for Hospital Emergency Services and Out-of-Network Emergency Services will be retrospectively reviewed by the Plan to determine if a Medical Emergency existed. If it is determined that a Medical Emergency as described herein did not exist and the Member's Primary Care Physician did not refer the Member for emergency care, then the Member shall be liable for the entire cost of such services.
4. Continuing or follow-up care is not Covered Out-of-Network unless such care is authorized by the Plan's Medical Director.
5. Care and treatment provided to a Covered Person once the Covered Person is Stabilized is not care obtained in an emergency.

Exclusions
Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Family Planning - Prescription Drugs	**Copayment/Coinsurance Required**

The Member pays the lesser of the Copayment/Coinsurance or the Pharmacy's Usual and Customary charge for up to a thirty (30) day supply which should not exceed one manufacturer's standard packaging, including but not limited to: topical creams, solutions, gels or ointments, nasal or oral inhalers.

Please reference Article I, Definitions for Pharmacy Definitions and Article IV, Schedule of Benefits Prescription Drugs for Coverage and Limitations.

In lieu of Brand Name Drugs, Generic Equivalent Drugs will be dispensed when substitution is permissible.

1. Infertility Drugs - Oral, Biologic Product, Biotech Products and Injectables	Not Covered

2. Infertility Drug Monitoring	Not Covered
3. Contraceptive Drugs, oral, injectable (e.g., Depo-Provera®), insertable (contraceptive rings e.g., NuvaRing®) and topical (e.g., patches)	
Generic	$10
Formulary Brand	$20
Non-Formulary Brand Name or Non-Formulary Generic	40% of Eligible Expenses ($40 minimum, $100 Maximum)
Mail Order Prescription Drugs	A ninety (90) day supply of Prescription Drugs is available for two (2) thirty (30) days supply Copayment(s). Copayments by tiers listed below apply to Mail Order Pharmacy.
Formulary Generic and Non-interchangeable Brand Name Drugs	$20
Formulary Brand Name Drugs	$40
Non-Formulary Brand Name or Non-Formulary Generic Drugs	40% of Eligible Expenses ($80 minimum, $150 Maximum)

Exclusions

1. Drugs not approved by the FDA or not indicated for the particular condition in at least one of these standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted) or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a □ and not experimental discussion), except as stated above under "Covered".
2. OTC (Over-The-Counter) non-prescription drugs
3. Prescription drugs which have an OTC equivalent
4. State restricted drugs
5. Any drug labeled, "Caution-Limited by Federal law to Investigational Use" or experimental drugs even though a charge is made to the patient
6. Take home drugs from the Hospital
7. Drugs for travel or recreation
8. Convenience items, including unit of use packaging for patient convenience
9. Drugs in unit dose packaging for institutional use
10. Infertility Drugs, Oral, Biologic Products, Biotech Products and Injectables and the monitoring of infertility drug therapy
11. Services and supplies for Norplant or other surgically implanted contraceptives
12. Non-Self Administered, Injectable Drugs as defined by the Plan
13. Biotech products (See Article IV, Biotech Products)
14. Contraceptive devices. (See Article IV, Family Planning Procedures and Devices)

15. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Family Planning - Procedures and Devices	**Copayment/Coinsurance Required**
1. Sterilizations (Tubal Ligation, Vasectomy)	20% of Eligible Expenses
2. Elective abortions (during the first trimester, limit 1 [one] per Contract Year, 2 [two] per lifetime)	20% of Eligible Expenses
3. Infertility counseling, testing to diagnosis	20% of Eligible Expenses
4. Contraceptive Devices	
Diaphragms and cervical caps	20% of Eligible Expenses
Fitting of diaphragms and cervical caps	Applicable office visit Copayment or Coinsurance applies

Definitions
Infertility is defined as the involuntary inability to conceive after twelve (12) months of unprotected intercourse.

Exclusions
1. Infertility drugs and the monitoring of drug therapy (See Article IV, Family Planning - Prescription Drugs)
2. Reversal of voluntary or induced sterilization procedures
3. Surrogate parenting procedures
4. Amniocentesis unless Medically Necessary
5. Egg or inseminated egg procurement, processing or banking
6. Assisted reproductive technology (ART) services except for artificial insemination as determined to be Medically Necessary and approved by the Plan. ART including but not limited to in vitro fertilization and embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), intracytoplasmic sperm injection (ICSI) and zygote intrafallopian transfer (ZIFT).
7. HI/LA typing (human leukocyte antigen)
8. Hormone pulsating infusions
9. Animal egg penetration testing
10. Sperm antibody testing
11. Testing after diagnosis of infertility
12. Treatment and surgical procedures to correct infertility
13. Please reference Article IV, Outpatient Services for Copayment/Coinsurance information.
14. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Hearing Aids and Related Services	**Not Covered**

Home Health Care Services	**Copayment/Coinsurance Required**
	$20 per day
IV Therapy administered through Home Health Care Services	20% of Eligible Expenses

Services and supplies include:

1. Home Health Care Services and supplies provided by a skilled nurse and/or Home Health aide on an intermittent or part-time basis, not full time, in accordance with the treatment plan that is ordered and monitored by the Primary Care Physician. Intermittent shall mean less than eight (8) hours per day and less than twenty-eight (28) hours per week. Home Health aide Coverage is included when the services are included in the Home Health agency's plan of care and are reasonable and necessary for the treatment of the Covered Person's illness or injury and a need for skilled services exists.
2. Rehabilitation therapy such as physical therapy, occupational therapy and speech therapy are subject to the limitations and Copayments applicable to those services as defined in Article IV, Rehabilitation Therapy, whether provided in the home or in another setting.

Exclusions

1. Custodial Care or domiciliary care is excluded from Coverage
2. Services, supplies, drugs or care that is provided, performed or ordered by an immediate family member (i.e., the Member, the Member's spouse or a child, brother, sister or parent of the Member's spouse) or Member of the household
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Hospice Care/Respite Care	**Copayment/Coinsurance Required**
Outpatient Hospice Care	No Charge
Respite Care - Inpatient or Outpatient; subject to Plan approval	No Charge

Hospice Care services are Covered for Members when all the following criteria are met:

1. The medical diagnosis projects a life expectancy of six months or less if the disease follows its normal course;
2. The patient and family agree that symptom and pain management rather than curative treatment are the goals of care;
3. The Primary Care Physician Prior Authorizes the Hospice Care services; and
4. A full-time caregiver in the home is available.

Exclusions

1. Inpatient custodial or domiciliary hospice program unless in lieu of acute hospitalization
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Hospital Services	**Copayment/Coinsurance Required**
Hospital Inpatient Services	$500 per admission
Emergency Services provided in an emergency room or provided in connection with an emergency room visit, such as an Observation Stay	$75 per emergency room visit. Waived if admitted as a hospital inpatient

Those Medically Necessary services and supplies generally performed and customarily provided by Hospitals only when prescribed, directed or authorized by a Member's Primary Care Physician or a Physician to whom the Member has been referred for care pursuant to an approved referral.

Except in an Emergency, Hospital Services must be prior authorized by the Plan. Covered Services received by the Member include:

1. Semi-private room and board. Private room only when Medically Necessary
2. General nursing care
3. Operating room and related facilities
4. Intensive care and cardiac care unit and related services
5. Anesthesia and oxygen service
6. Hospital ancillary services including laboratory, pathology, radiology, physical therapy, radiation therapy, and inhalation and respiratory therapy
7. Drugs, medications, Biologic Products and Biotech Products as prescribed and intended for use while the Member is a registered bed patient
8. Blood and the administration of whole blood and blood plasma
9. Special diets
10. Coordinated discharge planning services
11. Rehabilitation therapy, which includes physical, occupational, speech and cardiac, of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning. For specific Coverage limitations see Article IV, Cardiac Rehabilitation Therapy or Article IV, Rehabilitation Therapy.
12. Anesthesia and Hospital charges for dental care for a child or a disabled Member whose mental or physical condition requires dental treatment to be rendered in a Hospital or ambulatory surgery center

Exclusions

1. Family Planning Services (See Article IV, Family Planning - Procedures and Devices)
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Imaging Services	**Copayment/Coinsurance Required**
Outpatient Imaging Services 1. CT 2. MRI 3. PET 4. SPECT This Copayment/Coinsurance does not apply to any other radiology or nuclear medicine service.	$50

Immediate Care Services (See Urgent Care Services)

Mastectomy Services	**Copayment/Coinsurance Required**
	Applicable Copayment/Coinsurance for the specific Health Care Service provided shall apply

1. Medically Necessary services for the removal of all or part of the breast, including
   a. Prosthetic devices, and
   b. Reconstructive Surgery incident to the mastectomy including:
      i. All stages of reconstruction of the breast on which the mastectomy has been performed; and
      ii. Surgery and reconstruction of the other breast to produce symmetry;

      In the manner determined by the Member's Primary Care Physician or a Physician to whom the Member has been referred by the Primary Care Physician and the Covered Person to be appropriate.

Limitation
If the mastectomy Covered under this section is performed and there is no evidence of malignancy, Coverage is limited to the provision of prosthetic devices and Reconstructive Surgery for two (2) years following the mastectomy surgery.

Exclusions
Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Mental Health Services - Inpatient And Outpatient	**Copayment/Coinsurance Required**
Inpatient	
1. Mental Health Services	Same Copayment/Coinsurance as Inpatient Hospital Services
2. Partial hospitalization or day treatment in lieu of inpatient psychiatric care.	Same Copayment/Coinsurance as Inpatient Hospital Services
Outpatient	
1. Mental Health Services, short-term psychotherapy, crisis intervention and evaluation, psychiatric testing.	Same Copayment/Coinsurance as specialty office visit Copayment
2. Psychiatric Intensive Outpatient Program Services.	Same Copayment/Coinsurance as specialty office visit Copayment

Exclusions

1. Long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities
2. Mental Health Services for gambling addictions and paraphilia
3. Services for the treatment of alcoholism, drug abuse or chemical dependency including diagnosis, evaluation and treatment of detoxification (See Article IV, Chemical Dependency and Substance Abuse)
4. Experimental psychiatric procedures, pharmacological regimen and associated Health Care Services or procedures not consistent with accepted standard medical practice
5. Psychiatric therapy on court order or as a condition of parole or probation unless treatment otherwise would be Covered
6. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Morbid Obesity Services	**Copayment/Coinsurance Required**
	20% of Eligible Expenses, limited to one (1) per lifetime

Services and supplies include:

Non-experimental weight-loss surgery for Morbid Obesity when provided that non-surgical treatment, supervised by your Physician for at least eighteen (18) consecutive months, has been unsuccessful. Members who meet specific benefit criteria may qualify sooner than eighteen (18) months.

Exclusions

1. Weight management programs such as, but not limited to Jenny Craig®, Optifast® and Weight Watchers®
2. Please reference Article IV, Prescription Drugs, for specific drug coverage.
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Nutrition for Inherited Metabolic Disease	**Copayment/Coinsurance Required**
Generic formulas	$10
Brand Select formulas	$20
Brand Non-Select formulas	40% of Eligible Expenses ($40 minimum, $100 maximum)

Coverage

The nutrition for an Inherited Metabolic Disease, as mandated by Indiana State Law, means a formula that is:

1. intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
2. formulated to be consumed or administered enterally under the direction of the Covered Person's Participating Physician; and
3. Medically Necessary; and prescribed by a Covered Person's Participating Physician for treatment of the Covered Person's Inherited Metabolic Disease**.**

Exclusions

1. Oral formulas or supplements used for the dietary treatment of diseases and/or conditions other than Inherited Metabolic Diseases.
2. Parenteral formulas or supplements such as hyperalimentation
3. DME (Durable Medical Equipment) as defined by the Plan such as external ambulatory pumps and related components (See Article IV, Durable Medical Equipment)
4. Any enteral formula or supplement labeled "Caution – Limited by Federal law to Investigational Use" or experimental drugs even though a charge is made to the patient
5. Take home oral formulas or supplements and/or supplies from the Hospital
6. Convenience items, including unit of use packaging for patient convenience
7. Extra oral formulas or supplements for vacation, travel or to replace those that have been lost
8. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Orthotic and Prosthetic Devices	**Copayment/Coinsurance Required**
	20% of Eligible Expenses

Services include:

1. Orthotic and Prosthetic devices are Covered when Medically Necessary and authorized in accordance with the Network's precertification process and are included on the Plan Orthotic and Prosthetic Device list.
2. Components which are integral to the function of Medically Necessary Prosthetic Devices and authorized by the Plan.
3. Repair, adjustment or replacement of the Medically Necessary Orthotic and Prosthetic Devices or components caused by normal wear or by a change in the Covered Person's condition are Covered. Therapeutic shoes or the modification of shoes are limited to one pair per year based on Medical Necessity.
4. If the Plan Orthotic and Prosthetic Coverage criteria for a custom-molded Orthotic are not met but the criteria for a custom-fitted Orthotic are met, Coverage is for the least costly alternative.
5. One pair of refractive lenses or contact lenses following crystalline lens removal (primary cataract surgery) or the congenital absence of the eye.
6. Contact lenses as required for the treatment of keratoconus as Medically Necessary with Prior Authorization.

Exclusions

1. Eyeglasses and frames
2. Refractive lenses or contact lenses or the fitting thereof except for the first pair of refractive lenses following crystalline lens removal (primary cataract surgery) or the congenital absence of the eye or contact lenses for the treatment of keratoconus as Medically Necessary with Prior Authorization of the Plan
3. Wigs or hair prostheses
4. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Outpatient Surgical Services	**Copayment/Coinsurance Required**
Outpatient Surgical Services	$250 per outpatient surgical admission
Other Outpatient Services, including laboratory, pathology, radiology, physical therapy,	No Charge

radiation therapy, and inhalation
and respiratory therapy

Outpatient surgical services (except those performed in a physician's office) performed in a hospital or free-standing surgery center for therapeutic or diagnostic purposes requiring IV conscious sedation or anesthesia.

Except in an Emergency, Outpatient Surgical Services may require prior authorized by the Plan. Covered Services received by the Member include:

1. Operating room and related facilities
2. Anesthesia and oxygen service
3. General nursing care
4. Drugs, medications and Biologic Products, Biotech Products as prescribed and intended for use while the Member is a registered outpatient
5. Blood and the administration of whole blood and blood plasma
6. Anesthesia and Hospital charges for dental care for a child or a disabled Member whose mental or physical condition requires dental treatment to be rendered in a Hospital or ambulatory surgery center

Pervasive Developmental Disorders	**Copayment/Coinsurance Required**
Services for the treatment of a Pervasive Developmental Disorder prescribed by the Member's treating Physician in accordance with a treatment plan.	Applicable Copayment/Coinsurance for the specific Health Care Service provided shall apply

Exclusions
Any exclusion that could be in conflict with the services for the treatment of Pervasive Developmental Disorders does *not* apply.

Physician Services	**Copayment/Coinsurance Required**
Primary Care Physician Office Visit	$20 Copay per visit
Specialty and Referral Physician Office Visits	$20 Copay per visit
Primary Care Physician, Specialty and Referral Physician Visits in the Hospital	No Charge
Primary Care Physician, Specialty and Referral Physician in Home Visits, when provided by your Participating Physician	20% of Eligible Expenses

Services and supplies include:

1. Office visits, services and supplies for the determination and/or treatment of illness or prevention of same. These services include medical consultations, Surgical Services and procedures performed in the Physician's office, second opinion consultations, and specialist treatment services.
2. Routine maternity care including prenatal, antepartum and postpartum care unless Member is serving in capacity as a surrogate mother.
3. Periodic health appraisal examinations for Members who are less than eighteen (18) years of age for the prevention and detection of disease as recommended by the American Academy of Pediatrics.
4. For Members age eighteen (18) and older, history and periodic health evaluations (physical examinations for the prevention and detection of disease) limited to the extent Medically Necessary or appropriate.
5. Immunizations and inoculations (vaccine and injection of vaccine) based on the guidelines of the Advisory Committee on Immunization Practices (ACIP), or at the Plan's discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family Physicians (AAFP).
6. Hearing examinations, including an infant physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments.
7. Diabetes self-management training ordered in writing by a Participating Provider and provided by a licensed, registered or certified health care professional who has specialized training in the management of diabetes. Diabetes management training may be limited to:
   a. One or more visits after receiving a diagnosis of diabetes.
   b. One or more visits after receiving a diagnosis that represents a significant change in the Member's symptoms or condition that makes changes in the Covered Person's self management Medically Necessary.
   c. One or more visits for re-education or refresher training.
8. Breast and prostate cancer screening tests (PSA) include:
   a. One (1) baseline screening mammography before the age of forty (40) for a Member who is at least thirty-five (35) years old.
   b. Annual screening mammography if at risk and less than forty (40).
   c. Annual screening mammography for Members forty (40) years old or older.
   d. Any additional mammogram views needed for proper evaluation and ultrasound services, if Medically Necessary.
   e. At least one (1) PSA test annually for an individual who is at least fifty (50) years old.
   f. At least one (1) PSA test annually for an individual less than fifty (50) who is at high risk of prostate cancer according to the American Cancer guidelines.
9. Colorectal cancer examinations and laboratory tests, as mandated by Indiana State Law, must be Covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines for a Covered Person who is:
   a. At least fifty (50) years of age; or
   b. Less than fifty (50) years of age and at high risk for colorectal cancer.
10. Surgical Services including surgical assistance when Medically Necessary and anesthesiology services performed in connection with Surgical Services.
11. Physician's services for visits and examinations, including consultation time and time for personal attendance with the Member during a confinement in a Hospital or Skilled Nursing Facility when a Member is confined in such facility.
12. Allergy testing
13. Diagnostic radiologic, laboratory and other services such as electrocardiography, electroencephalography, and the use of radioactive isotopes.

14. Therapeutic radiological services including radiation therapy and radioactive isotope therapy.

Exclusions

1. Physical examinations and related tests and reports for the purpose of obtaining or maintaining employment, insurance, governmental licensure, attending camp, participating in sports, admissions to school and for premarital purposes. Also excluded are employer requested annual physical examinations and other services or supplies that are not Medically Necessary for the maintenance or improvement of the health of a Member.
2. Immunizations and inoculations (vaccine and injection of vaccine) required for travel or recreational purposes
3. Allergy Serum/Extract
4. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Prescription Drugs	**Copayment/Coinsurance Required**

The Member pays the lesser of the Copayment/Coinsurance or the Pharmacy's Usual and Customary charge for up to a thirty (30) day supply which shall not exceed one manufacturer's standard packaging, unless Medically Necessary. Examples of a manufacturer's standard packaging include but are not limited to: topical creams, solutions, gels or ointments, otics, ophthalmics, nasal or oral inhalers.

In lieu of Brand Name Drugs, Generic Equivalent Drugs will be dispensed when substitution is permissible.

Over-the-Counter (OTC) Select Drugs	$5
Formulary Generic and Non-interchangeable Brand Name Drugs	$10
Formulary Brand Name Drugs	$20
Non-Formulary Brand Name or Non-Formulary Generic Drugs	40% of Eligible Expenses ($40 minimum, $100 maximum)
Mail Order Prescription Drugs	A ninety (90) day supply of Prescription Drugs is available for two (2) thirty (30) days supply Copayment(s). Copayments by tiers listed below apply to Mail Order Pharmacy.
Formulary Generic and Non-interchangeable Brand Name Drugs	$20
Formulary Brand Name Drugs	$40
Non-Formulary Brand Name or Non-Formulary Generic Drugs	40% of Eligible Expenses ($80 minimum, $150 Maximum)

To be Covered, a Prescription Drug must be

1. Medically Necessary, and
2. Provided by a Plan Participating Pharmacy, and
3. Prescribed by the Member's Primary Care Physician or his authorized agent, or a Physician to whom the Member has been referred for care pursuant to an approved referral and
4. An FDA approved drug requiring a prescription by Federal law, and
5. Indicated for the particular condition being treated. If the drug has not been approved by the FDA for the particular indication being treated, it is Covered if:
   a. The drug is recognized for the treatment of a particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a Ψ and not experimental discussion, or
   b. The drug is demonstrated for a particular condition/type of cancer to be safe and effective in at least two (2) formal clinical studies, the results of which have been published in peer reviewed professional medical journals published in the United States, Great Britain, Canada or Australia.
6. When Pharmacy Coverage is selected by the Employer Group, Pharmacy Coverage also pertains to the sections listed below in Article IV:
   a. Diabetic Drugs and Supplies
   b. Family Planning Prescription Drugs
   c. Self-Administered Prescription Drugs

Limitations

1. Quantity Limits have been placed on certain medications as a quality management measure to promote safe and appropriate utilization based on the current medical literature. This list of medications is defined in the Pharmacy Program.
2. Post pay drugs are medications that may be prescribed for a Member for a condition for which it is not FDA indicated, or for a condition, which is an excluded benefit. This list of medications is defined in the Pharmacy Program.
3. Step therapy drugs are medications that may have pre-requisite therapies as a determinate factor in directing them to a specific level of Coverage. This list of medications is defined in the Pharmacy Program. For these step therapy prescription drugs, the Plan reserves the right to ensure that the following Coverage criteria are met:
   a. The prescription drug is for the treatment of a covered medical condition, and
   b. Established step-therapy guidelines that are developed and maintained by the Plan are followed,

   Failure to comply with (a) and (b) may result in a higher Copay.
4. Safety issues can dictate a medication being blocked by the Plan for drugs that pose a public health concern. Some examples may be a manufacturers' drug package insert that contains black box warnings, post marketing surveillance incident reports or as defined by the Plan.
5. It is possible some prescription drugs may move from select to non-select categories or vice-versa at the discretion of the Plan as recommended by the Pharmaceutical and Therapeutics Committee throughout the Contract Year.
6. Some Prescription Drugs require Prior-Authorization for Coverage. This list of medications is defined in the Pharmacy Program and may change throughout the year as determined by the Pharmacy and Therapeutics Committee.

Treatment Limitation

Members can receive up to three (3) months of treatment for nail onychomycosis in a ninety (90) day

period if approved by the Plan. This therapy is limited to one course of therapy per lifetime.

Exclusions

1. Drugs not approved by the FDA or not indicated for the particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I will only be accepted) or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a and not experimental discussion), except as stated above under "Covered".
2. DME (Durable Medical Equipment) as defined by the Plan
3. OTC (Over-The-Counter) non-prescription drugs and supplies; OTC Select Drugs are subject to a $5 copay
4. Prescription drugs which have an OTC equivalent.
5. Any prescription from the non-sedating antihistamine or low-sedating antihistamine class will not be covered when any form of non-sedating antihistamine becomes available OTC.
6. State restricted drugs
7. Any drug labeled, "Caution-Limited by Federal law to Investigational Use" or experimental drugs even though a charge is made to the patient
8. Take home drugs from the Hospital
9. Drugs for travel
10. Vitamins not requiring a prescription by law
11. Drugs for cosmetic purposes
12. Drugs to enhance athletic performance
13. Convenience items, including unit of use packaging for patient convenience
14. Drugs in unit dose packaging for institutional use
15. Non-Self Administered Injectable Drugs as defined by the Pharmacy Program
16. Biotech Drugs (See Article IV, Biotech Products)
17. Infertility Drugs (See Article IV, Family Planning Prescription Drugs and Devices)
18. Contraceptive Drugs and devices. (See Article IV, Family Planning Prescription Drugs and Devices)
19. Diabetic Drugs And Supplies (See Article IV, Diabetic Drugs and Supplies)
20. Food supplements when prescribed for the purpose of weight loss or for treatment of obesity
21. Diet pills (anorexiants)
22. Retin-A (Covered if treating a Medical Condition)
23. Self-Administered, Injectable Drugs (See Article IV, Prescription Drugs - Self-Administered Injectable)
24. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Reconstructive Surgery **Copayment/Coinsurance Required**

Subject to applicable inpatient/outpatient Copayment/Coinsurance

Coverage is provided for Reconstructive Surgery for the prompt (i.e., as soon as medically feasible and medically appropriate) repair of birth or growth defects, accidental injury or for the improvement of impaired physiological functioning of the body resulting from disease, birth or growth defects or accidental injury. (Refer to Article IV, Mastectomy Services).

Exclusions

1. Cosmetic or reconstructive services and procedures and all associated expenses including, but not limited to, pharmacological regimens, nutritional services, aesthetic Reconstructive Surgery, salabrasion, chemosurgery or other such skin abrasion procedures associated with the removal of

scars, tattoos, or age spots. Psychological reasons are not considered an argument for Coverage.
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Rehabilitation Therapy - Occupational, Physical and Speech	**Copayment/Coinsurance Required**
	Outpatient - $20 per visit Inpatient - subject to applicable Copayment/Coinsurance

Inpatient and outpatient speech and occupational services and physical therapy for Medically Necessary treatment of acute illness or injury are Covered only if and to the extent that significant potential exists for progress toward a previous level of functioning as determined by the Plan's Medical Director. Acute is defined as having rapid onset, severe symptoms and a defined course.

Exclusions
1. Rehabilitation therapy for non-acute illness or injury as determined by the Plan
2. Behavioral training, remedial education and the evaluation and treatment of learning disabilities
3. Developmental testing after diagnosis
4. Sensory integration therapy
5. Auditory integration therapy
6. Alternative/Complimentary medicine therapies, including but not limited to, acupuncture, hypnotherapy, biofeedback, massage therapy, herbal remedies, aromatherapy and chiropractic services
7. Naturopathic and Christian Science practitioners
8. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Surgical Dressings	**Copayment/Coinsurance Required**
	20% of Eligible Expenses

Surgical dressings applied by the Member in the home are Covered when Medically Necessary and authorized by a Plan Physician and the Plan, and included on the Plan's Surgical Dressing List.

Exclusions
1. Surgical dressings applied by the Member, which have not been authorized by a Plan Physician and the Plan
2. Surgical dressings used primarily for Member convenience
3. Surgical dressings that are not part of a Physician directed Home Health care plan
4. Take home surgical dressing supplies from a Hospital or Physician's office, except for surgical dressings authorized by the Plan
5. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Temporomandibular Joint Dysfunction or Disease (TMJ)	**Copayment/Coinsurance Required**
Medical services for the treatment of Temporomandibular Joint Dysfunction or Disease (TMJ)	Applicable office visit Copayment or Coinsurance applies

covered when Medically Necessary and approved by the Primary Care Physician and the Plan's Medical Director; due to injury or medical condition.

Exclusions

1. Dental services for the treatment of Temporomandibular Joint Dysfunction (TMJ) or disease
2. Conventional or surgical orthodontics
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Transplants - Organ, Tissue and Bone Marrow	**Copayment/Coinsurance Required**
Limited to a lifetime maximum benefit per Member for all transplant services, under this Plan or any tissue transplant benefit between the Member and the Company	$2,000 copay ($1,000,000) one million dollars lifetime maximum

Transplant services are covered only when the transplant recipient is a Member of the Plan.

Benefit Period: Total of three hundred and sixty-five (365) days beginning one (1) day immediately prior to a Covered Transplant Procedure or first (1st) myeloblation therapy (high dose chemotherapy and/or irradiation).

Eligible medical expenses include the following:
Any of the following Medically Necessary human organ and tissue transplants:

Adult Procedures

1. Bone marrow or stem cell including:
   - Autologous bone marrow including high dose chemotherapy
   - Related allogeneic bone marrow including high dose chemotherapy
   - Unrelated allogeneic bone marrow including high dose chemotherapy
2. Heart
3. Heart/Lung
4. Lung
5. Liver
6. Pancreas and kidney when performed simultaneously or pancreas transplant after a kidney transplant (Kidney transplant alone may be covered under medical and is not part of this transplant benefit)
7. Cornea
8. Kidney

Pediatric Procedures

1. Bone marrow and stem cell including:
   - Autologous bone marrow including high dose chemotherapy
   - Related allogeneic bone marrow including high dose chemotherapy

- Unrelated allogeneic bone marrow including high dose chemotherapy

2. Heart
3. Liver
4. Cornea
5. Kidney

Transplant Related Expenses

Transplant related expenses mean Medically Necessary items that are required as a result of a Covered transplant procedure and would not be incurred if the Member were not having a Covered transplant procedure. Services related to diagnosis causing the need for a Covered transplant procedure which would have been performed whether or not the Member received a Covered transplant procedure are not considered a transplant related expenses. Transplant related expenses during a transplant benefit time period include only the following:

1. Acquisition costs, also referred to as procurement (live or cadaver). Acquisition costs include Medically Necessary services in connection with the preparation, harvesting and storage of bone marrow, stem cell or solid organ for a Covered transplant. For a living donor, acquisition costs also include the Medically Necessary Inpatient services for the recovery of the donor post surgery and any complications that arise as a direct result of the actual acquisition procedure for a period of six weeks from the date of the acquisition or as otherwise determined within the limits determined by the Plan. Cord blood is payable if the transplant is approved. Harvesting and storage of cord blood, bone marrow or stem cells for a possible future transplant is not eligible under this transplant benefit.
2. Hospital charges and professional fees for the Covered transplant procedure.
3. Inpatient services, outpatient services or Home Care Services for treatment of complications of bone marrow or stem cell transplant or for complications and/or rejection of the transplanted organ.
4. Physician fees for Medical Care following Hospital discharge, which are identified as post transplant.

Exclusions and Limitations

1. Transplants are not Covered unless provided in a Hospital approved by the Plan
2. Medical and Hospital services of a donor or prospective donor when the recipient of the transplant is not a Member of the Plan
3. Health Care Services and associated expenses for transplants involving mechanical or animal organs
4. Transplantation of two (2) or more organs simultaneously unless prior authorized by the Plan
5. Neither the Plan nor its Participating Providers assure the availability of organs for transplant
6. Transplant related services for any potential/prospective donor, unless the transplant procedure has been prior approved by the Plan
7. Experimental/research medical, surgical, and pharmacological regimes, and associated Health Care Services, and/or those services or procedures that are not consistent with accepted standard medical practice
8. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Urgent Care Services – In-Network and Out-of-Network	**Copayment/Coinsurance Required**
Physician office visits	$20 Copay per visit
Emergency room visit	$75 per emergency room visit. Waived if admitted as a Hospital Inpatient

Immediate/Urgent Care Center visit	$35 Copay per visit

For Urgent Care Services, the Covered Person must contact his/her Participating Primary Care Physician unless the Covered Person is beyond a fifty (50) mile radius of his/her Primary Care Physician's office. When outside the fifty (50) mile radius of the Primary Care Physician's office, a referral from a Participating Provider is not required before seeking treatment, however, continued care Out-of-Network is not Covered unless Prior Authorized by the Primary Care Physician.

Exclusions
Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Vision Care	**Copayment/Coinsurance Required**

1. Medical eye care, consisting of an examination of the eye(s) and refraction that is Medically Necessary due to an existing medical condition, disease or injury to the eye, or a therapeutic intervention, is a covered service. Examinations are covered when Medically Necessary and performed by a Participating Provider with a Primary Care Physician referral and network authorization, if required.
2. Medical and surgical treatment of diseases of the eye.

Exclusions

1. Services which are not Medically Necessary or not required in accordance with accepted standards of medical practice. For example, radial keratotomy [photorefractive keratectomy (PRK) and ophthalmic training (eye training) for the treatment of reading, behavioral, and emotional disorders.]
2. Eye refractions, corrective lenses and frames. Services which are not Medically Necessary or not required in accordance with accepted standards of medical practice. For example, radial keratotomy [photorefractive keratectomy (PRK) and ophthalmic training (eye training) for the treatment of reading, behavioral, and emotional disorders.]
3. Corrective lenses and frames except as listed above
4. Contact lenses and associated services, including examination and fittings except as listed above
5. Eye exercises (see Non-Covered Services, item number 1)
6. Replacement of lenses due to loss, theft, or neglect
7. Contact lenses and associated services, including examination and fittings
8. Eye exercises
9. Replacement of lenses due to loss, theft, or neglect

ARTICLE V - GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions

The following services and benefits are NOT Covered by the Plan. Please refer also to the specific exclusions that are listed with the Covered benefits in Article IV.

A. Any services, Hospital, professional or otherwise, which are not provided, arranged for, authorized or approved by the Member's Primary Care Physician or authorized by the Medical Director of the Plan. This limitation shall not apply to Emergency Services. The Plan reserves the right to evaluate and determine Coverage of care not directly provided or Prior-Authorized by Primary Care Physicians. Emergency Services Coverage shall only provide for care that is Medically Necessary for the treatment of the Medical Emergency and shall be subject to the terms, conditions, exclusions and limitations of this contract.

B. Any medical service, prescription drug, medicine, equipment, supply or procedure directly or indirectly related to a service which is not Medically Necessary or which is not a Covered service in part or in full. Services, recommended by a Participating Physician, that are not services Covered by the Plan.

C. Services that are not Medically Necessary or not required in accordance with accepted standards of medical practice.

D. Personal comfort or convenience items in and out of the Hospital such as television, telephone, private room (unless Medically Necessary), housekeeping, homemaker service, and room and board as part of Home Health Care.

E. Special diets at home including but not limited to , supplemental feedings (e.g., Slimfast™, Ensure™, Sustacal™) except for Nutrition for Inherited Metabolic Disease (see Article IV, Nutrition for Inherited Metabolic Disease).

F. Private duty nurse unless determined to be Medically Necessary.

G. Conventional or surgical orthodontics.

H. Conventional or surgical orthognathics, unless Medically Necessary as determined at the Plan's sole discretion.

I. Orthoptics or vision training and any associated supplemental testing.

J. Custodial care, nursing home care, rest cures, domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.

K. Experimental/investigational medical, surgical, or psychiatric procedures and pharmacological regimens, and associated Health Care Services, and/or those services or procedures that are not consistent with accepted standard medical practice, or services requiring approval by any governmental authority prior to use where such approval has not been granted or services not approved for Coverage by Medicare.

L. Any care for military service connected disabilities and conditions that the Member is entitled to receive, if reasonably available, and actually received in a Veteran's Administration Hospital, clinic, or other facility in which the Member is entitled to benefits. Any care for conditions that federal, state or local law requires to be treated in a public facility.

M. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy or counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs and all other procedures and equipment developed for or used in the treatment of impotency and all related diagnostic testing.

N. Weight management programs such as, but not limited to Jenny Craig®, Optifast® and Weight Watchers®.

O. Care of flat feet; supportive devices of the foot, such as arch supports or pelvic/spinal stabilizers (even if specifically made for and fitted to a particular individual); care or treatment of corns, bunions and callouses of the feet, nails of the toes including clipping, debriding and treatment for ingrown toenails, care of fallen arches, weak feet or chronic foot strain, hypertrophy or hyperplasia of the skin of the feet unless Medically Necessary because of diabetes or circulatory problems.

P. Out-of-Network Services rendered to the Covered Person while traveling, which could reasonably have been foreseen by the Member prior to leaving and/or against Physician advice. For example, medical and Hospital costs resulting from a normal full-term delivery of a baby, except those services Prior Authorized in writing by the Plan.

Q. Travel and transportation as a treatment modality or to receive consultation or treatment. Transportation costs for a living donor.

R. Hair analysis unless used as a diagnostic tool for heavy metal poisoning.

S. Services for injuries or illnesses arising out of or in the course of the Member's employment that are Covered under any worker's compensation or occupational disease act or law.

T. Benefits otherwise provided in this Certificate, which the Plan is unable to provide because the benefit is illegal.

U. Any service or benefit not expressly Covered under this contract even if provided or referred by a Participating Provider.

V. Services rendered prior to the effective date of Coverage or subsequent to termination.

W. Maternity care related to a Member's serving in the capacity of a surrogate mother.

X. Home birth services and birth centers.

Y. Immunizations for travel.

Z. Sensory integration therapy.

AA. Auditory integration therapy.

BB. Services or supplies for or related to developmental delays except for Pervasive Developmental Disorders (See Article IV, Pervasive Developmental Disorders), learning disabilities, hyperkinetic syndromes or mental retardation. Behavioral training and remedial education.

CC. Developmental testing after diagnosis.

DD. Testing to evaluate school performance and/or diagnose or treat learning disabilities.

EE. Alternative/Complimentary medicine therapies, including but not limited to, acupuncture, aromatherapy, biofeedback, chiropractic services, depuration (except for chelation for iron or lead poisoning), herbal remedies, hypnotherapy and massage therapies.

FF. Naturopathic and Christian Science practitioners.

GG. Marriage counseling.

HH. Take home and over-the-counter drugs and non-diabetic supplies that do not require a prescription by Federal Law.

II. Services, supplies, drugs or care that is provided, performed or ordered by an immediate family member (i.e., the Member, the Member's spouse or a child, brother, sister or parent of the Member's spouse) or Member of the household.

JJ. Treatment for hair loss or hair removal regardless of medical condition or cause.

KK. Health Care Services resulting from a Member's participation in a riot or insurrection, or received while in the commission of a felony, or in the case of a minor, for an offense that would be a felony if committed by an adult. Services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in the custody of federal, state or local law enforcement authorities, including work release programs.

LL. Dental services for the treatment of Temporomandibular Joint Dysfunction (TMJ) or disease.

MM. Hearing Aids and Related Services.

NN. Vision care and materials except for Medically Necessary treatment for existing medical condition, disease or injury to the eye.

OO. Services and supplies for Skilled Nursing Facilities.

PP. Telephone consultations, charges for failure to keep a scheduled visit.

QQ. Services which are solely performed to preserve the present level or function or prevent regression of functions for an illness, injury or condition which is resolved or stable.

Limitations

The rights of Members and obligations of the Plan and its Participating Providers hereunder are subject to the following limitations:

A. Circumstances Beyond Control of the Plan
Should circumstances arise not reasonably within the control of the Plan (including but not limited to major disasters, epidemics, complete or partial destruction of buildings or facilities, riots, civil insurrection) that cause delay or impracticality in provision of Health Care Services under this contract, the Plan will make a good faith effort to arrange for alternative methods of providing Coverage. In such event, the Plan will arrange for the provision of Covered services to the extent practical, but neither the Plan nor its Providers shall incur liability or obligation for any delays in providing or arranging such Coverage.

B. Limitations on Choice of Providers
Members of the Plan must use the Plan's Participating Providers as explained in this contract. The Plan's Participating Providers may be subject to change from time to time with respect to individual practitioners, organizations or institutions. The Plan does not guarantee the length of service for any of its Participating Physicians, Hospitals or providers.

ARTICLE VI - SEEKING MEDICAL CARE, INCLUDING EMERGENCY SITUATIONS AND CHANGING PRIMARY CARE PHYSICIANS

A. In all circumstances, Covered Persons are required to contact their Primary Care Physician for advice and concurrence prior to seeking medical care, including health maintenance and preventive services, unless the nature of an Emergency condition effectively precludes such action unless specified otherwise herein.

B. If a Covered Person is hospitalized under an Emergency condition, the Covered Person or the Subscriber in the case of a minor Covered Person must notify the Plan of the fact of the Covered Person's hospitalization and must request the transfer of the Covered Person's care to a Primary Care Physician. Notification and request for care from a Primary Care Physician should be received by the Plan within a period of forty-eight (48) hours if the Covered Person is hospitalized beyond forty-eight (48) hours. In the case of a Covered Person who by reason of medical condition is unable to communicate said forty-eight (48) hours, shall be extended until forty-eight (48) hours after the Covered Person regains the ability to communicate.

C. A Covered Person may change Primary Care Physicians within the same Network every ninety (90) days, but no more frequently than twice yearly. A Covered Person may change their Network only during an Open Enrollment period except when the Covered Person moves into a new Network Service Area. This change may be accomplished by completing the required paperwork at least two (2) weeks before that change is to take effect or by contacting Member Services, either by telephone, email, mail or facsimile, as appropriate. Other than an Emergency situation, should a Covered Person go to a Physician other than the Primary Care Physician designated in writing to the Plan or to a Physician referred by the designated Primary Care Physician, the benefits of this Plan may not be paid.

D. A Covered Person is responsible for presenting their insurance information to the provider at the time of service. Failure to do so within ninety (90) days will result in denial of claim for service.

ARTICLE VII - MEDICAL REFERRALS AND CASE MANAGEMENT

A. Medical Referrals
A Primary Care Physician will determine the need for referrals and make necessary medical referrals of Covered Persons to other Participating Providers.

A Primary Care Physician will make necessary referrals of Covered Persons to other Participating Providers, except when there is no Participating Provider for the type needed in the Network Service Area.

Some services may require Prior Authorization by the Covered Person's Network.

B. Case Management
Cases accepted into the case management program by the Utilization Review Department may, under the approval of the Medical Director and the department head, utilize a cost effective alternative treatment protocol where benefits are not enumerated in the benefit plan if it does not compromise quality of care.

ARTICLE VIII - EXPERIMENTAL EXCLUSION PROCESS AND DECISION-MAKING CRITERIA

Experimental treatment evaluations will be based on the existence of any of the following:

1. Whether or not approval from the Food and Drug Administration (FDA) exists at the time of use or proposed use;
2. The treatment is the subject of a current investigational new drug or new device application on file with the FDA;
3. The treatment is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
4. The treatment is being provided pursuant to a written research protocol which describes among its objectives, determinations of safety, efficacy in comparison to conventional alternatives, toxicity;
5. The treatment is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board ("IRB") as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS").
6. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research setting or that the treatment is not effective;
7. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity or effectiveness compared with conventional alternatives; or
8. There is insufficient support in peer-reviewed literature for safety and/or efficacy as determined by the Plan's Technology Assessment Committee (TAC); or
9. The treatment is not investigational in itself pursuant to the above and would not be Medically Necessary, but for the provision of a drug, device, treatment or procedure which is Experimental.

ARTICLE IX - COORDINATION OF BENEFITS, SUBROGATION

A. Model COB Contract Provisions
Coordination of this Group contract's Benefits with other Benefits. This coordination of benefits (COB) provision applies when a person has health Coverage under more than one plan. "Plan" is defined below. The order of benefit rules below determine which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. Definitions
1. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated Coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a. "Plan" includes: group insurance, closed panel or other forms of group or group-type Coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; other governmental benefits, as permitted by law.
   b. "Plan" does not include: individual or family insurance; closed panel or other individual Coverage (except for group-type Coverage); amounts of Hospital indemnity insurance of $200 or less per day; school accident type Coverage; benefits for non-medical components of group long term care policies; Medicare, Medicare supplement policies, Medicaid policies, and Coverage under other governmental plans, unless permitted by law.
   c. Each contract for Coverage under (a) or (b) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. The order of benefit determination rules determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the plan. (Member or Person?)

   When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

3. "Allowable expense" means a health care service or expense, including deductibles and Copayments, that is Covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not Covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses.
   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides Coverage for Hospital private rooms) is not an allowable expense.
   b. If a person is Covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

c. If a person is Covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
d. If a person is Covered by one plan that calculates its benefits or services on the basis of usual or customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.
e. The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, precertifications of admissions and preferred Provider arrangements.

4. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no Coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed panel plan" is a plan that provides health benefits to Covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.

6. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

7. "Covered Persons with End Stage Renal Disease." The Plan's payer status with respect to Covered Persons entitled to or eligible for Medicare on the basis of end stage renal disease shall be determined as follows:
   a. In the event a Covered Person becomes eligible for or entitled to Medicare on the basis of end state renal disease and the Plan is not the primary payer under this Article IX prior to such eligibility or entitlement, Medicare shall be the primary payer of benefits and the provisions of Article IX of the Plan shall apply to Covered charges payable by the Plan.
   b. In the event a Covered Person becomes entitled to Medicare on the basis of age or disability at the onset of or during the thirty (30) month period following entitlement or eligibility due to end stage renal disease, the Plan shall be the primary payer of benefits throughout the entire thirty (30) month period and Covered charges payable under the Plan will not be reduced by any amounts payable under Medicare.

8. "Medicare as Primary Payer." The following rules shall apply in the event Medicare is the primary payer of medical benefits for a Covered Person pursuant to applicable federal law:
   a. Covered charges that would otherwise be payable under this Plan for any Health Care Services shall first be determined without regard to the amount of benefits payable under Medicare, and then reduced (but not below zero) by the amount of benefits payable under Medicare.
   b. In the event a Covered Person incurs charges for Health Care Services from a Participating Medicare Provider or a Provider who is not a Participating Medicare Provider but is accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed the allowable charge under the fee schedule used by Medicare for such Provider or Participating Medicare Provider.
   c. In the event a Covered Person incurs charges for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting payment on an assignment-related

basis, such charges shall not be Covered charges to the extent they exceed 115% of the allowable charge under the fee schedule used by Medicare for such Provider or other applicable limit.

In addition to the rights and authorities set forth herein, the Plan Administrator reserves the right to use its discretion in determining which limit(s) is/are applicable to charges incurred by a Covered Person for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting payment on an assignment-related basis.

9. "Deemed Entitlement to Medicare." Any Covered Person who is an eligible retiree or the spouse of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B Coverage for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medicare Coverage.

10. "Compliance with Medicare Secondary Payer Rules." Article IX shall be interpreted and administered in accordance with Section 1862 of the Title XVIII of the Social Security Act and any regulation or other official guidance issued thereunder. In the event of a conflict between this Article IX and such statute, regulation or guidance, such statute, regulation or guidance shall govern.

C. Order of Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary Coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
    a. Non-Dependent or Dependent. The plan that covers the person other than as a Dependent (for example, as an employee, Member, Subscriber or retiree) is primary, and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as other than a Dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, Member, Subscriber or retiree is secondary, and the other plan is primary.
    b. Child Covered Under More Than One Plan. The order of benefits when a child is Covered by more than one plan is:
        i. The primary plan is the plan of the parent whose birthday is earlier in the year if:
            1. The parents are married;
            2. The parents are not separated (whether or not they have ever been married);
            3. A court decree awards joint custody without specifying that one party has the responsibility to provide health care Coverages;
            4. If both parents have the same birthday, the plan that Covered either of the parents longer is primary.

ii. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care Coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the decree.

iii. If the parents are not married, or are separated (whether or not they ever have been married) or divorced, the order of benefits is:

1. The plan of the custodial parent;
2. The plan of the spouse of the custodial parent;
3. The plan of the non-custodial parent; and then
4. The plan of the spouse of the non-custodial parent.

c. Active Or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person were an Eligible Dependent of a person Covered as a retiree and an employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided for an individual as a retired worker and as an Eligible Dependent of an actively working spouse will be determined under this rule labeled B (9).

d. Continuation of Coverage. If a person whose Coverage is provided under a right of continuation provided by federal or state law also is Covered under another plan, the plan covering the person as an employee, Member, Subscriber or retiree (or as the person's Dependent) is primary, and the continuation Coverage is secondary. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e. Longer or Shorter Length of Coverage. That plan that Covered the person as an employee, Member, Subscriber or retiree longer is primary.

f. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

D. Effect On The Benefits of This Plan

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this plan to pay any allowable expenses, not otherwise paid during the claims determination period. As each claim is submitted, this plan will:
   a. Determine its obligation to pay or provide benefits under its contract;
   b. Determine whether a benefit reserve has been recorded for the Covered person;
   c. Determine whether there are any unpaid allowable expenses during the claims determination period.

   If there is a benefit reserve, the secondary plan will use the Covered Person's benefit reserve to pay up to 100% of total expenses incurred during the claims determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claims determination period.

2. If a Covered Person is enrolled in two or more closed panel plans, and if for any reason (including the provision of service by a non-panel Provider), benefits are not payable by one closed panel plan. COB shall not apply between that plan and other closed panel plans.

E. Right To Receive and Release Needed Information
Certain facts about health Coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Each person claiming benefits under this Plan must give Plan any facts it needs to apply those rules and determine benefits payable. Failure to comply may result in non-payment of claims.

F. Facility of Payment
A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Plan. Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery
If the amount of the payments made by Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

H. Subrogation
Subrogation is the substitution of one person or entity in the place of another with reference to lawful claim, demand or right. The Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, of any Covered Person from any person or entity, including his or her employer, for the reasonable value of services provided under the Group Service Agreement. The Plan may require assignment to the rights of recovery from the Covered Person, to the extent of the reasonable cash value of services and benefits provided by it plus reasonable costs of collection. Covered Persons agree to reimburse the Plan for any such services whether the benefits paid arise from any person, corporation, entity, no-fault Coverage, liability insurance of any person, underinsured motorists Coverage, medical pay coverage under a homeowners' insurance policy, automobile insurance policy, and other insurance policies or funds.

M•Plan will be entitled to the reimbursement from any recovery (whether by way of settlement, arbitration, award, or in satisfaction of a judgment and irrespective of whether the recovery is deemed or characterized as a recovery for medical expenses, pain and suffering, attorneys' fees, any other elements of damages) even if that recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate the Covered Person or dependent for the injury or illness.

The Covered Person shall cooperate with the Plan in protecting the Plan's legal rights under these subrogation provisions and acknowledges that the Plan's subrogation rights shall be considered as the first priority claim against any person or entity, to be paid before any other claims which may exist are paid, including claims for general damages by the Covered Person. M•Plan will automatically have a lien upon any amounts the Covered Person or dependent recovers from a third party to the extent of the benefits paid by M•Plan arising out of the applicable injury or illness for which the recovery is made. The Covered Person may be required to sign a document to this effect before M•Plan will pay any benefits.

The Covered Person shall do nothing to prejudice the Plan's right under this provision, either before or after the need for services or benefits under the Group Service Agreement. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including the right to bring suit in the name of the Covered Person. The Plan may collect, at its option, amounts from the proceeds of any settlement or judgment that may be recovered by the Covered Person or his or her legal representative, regardless of whether or not the Covered Person whether or not the Covered Person has been fully compensated. Any proceeds of settlement or judgment shall be held in trust by the Covered Person for the benefit of the Plan under these subrogation provisions, and the Plan shall be entitled to recover reasonable attorney fees from the Covered Person incurred in collecting proceeds held by the Covered Persons.

In the event a Covered Person or Eligible Dependent settles, recovers or is reimbursed by any third party or Coverage, the Covered Person or Eligible Dependent agrees to hold any such funds received in trust for the benefits of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of the injury or condition.

The Covered Person and Eligible Dependent(s) agree that they will make a decision on whether to pursue any claims for recovery against third parties within ninety (90) days of the date of the accident or occurrence that led to the injury or condition for which the Plan benefits are sought, and will so notify M•Plan in writing within that ninety (90) day period. In the event the Covered Person or Eligible Dependent decides not to pursue any and all third parties or fails to notify M•Plan within ninety (90) days of the accident or occurrence of its intent not to do so, the Covered Person and any Eligible Dependent(s) authorize M•Plan to pursue, sue, compromise or settle any claims in their name, agree to execute any and all documents necessary for M•Plan to pursue the claims and agrees to cooperate fully with M•Plan in the prosecution of any such claims. M•Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person or Eligible Dependent pursuing a claim against any third party or Coverage.

If the Covered Person or any of the Covered Person's Dependents fail to comply with the Subrogation provisions set out above, M•Plan has the right to terminate the Coverage of the Covered Person and Dependents under this Plan.

I. Effect of Medicare
The provisions of this section shall apply to any Covered Person who is an eligible employee, an eligible retiree, or the spouse of an eligible employee or eligible retiree and who is eligible for Medicare Coverage.

J. Eligible Employees and Spouses
In the event a Covered Person attains age 65 and is either an eligible employee or the spouse of an eligible employee, the Covered Person may elect to have either the Plan or Medicare be the primary payer of medical benefits. In the event the Covered Persons designates the Plan as primary payer, Covered charges payable under the Plan will not be reduced by any amounts payable under Medicare. In the event the Covered Person designates Medicare as the primary payer, the provisions of Deemed Entitlement to Medicare shall not apply and the Covered Person's Coverage under the Plan shall cease.

K. Eligible Retirees and Spouses
In the event an eligible retiree or the spouse of an eligible retiree attains age 65 and is not Covered under an employer group health plan by virtue of the individual's current employment status under section 1862 (b) of the Social Security Act, Medicare shall be the primary payer of benefits and the

provisions of Deemed Entitlement to Medicare shall apply to Covered charges payable by the Plan.

L. Covered Persons With End Stage Renal Disease
The Plan's payer status with respect to Covered Persons entitled to or eligible for Medicare on the basis of end stage renal disease shall be determined as follows:

1. In the event a Covered Person becomes eligible for or entitled to Medicare on the basis of end stage renal disease and the Plan is not the primary payer prior to such eligibility or entitlement, Medicare shall be the primary payer of benefits and the provisions of Deemed Entitlement to Medicare of the Plan shall apply to Covered charges payable by the Plan.
2. In the event a Covered Person becomes entitled to Medicare on the basis of age or disability at the onset of or during the thirty (30) month period following entitlement or eligibility due to end stage renal disease, the Plan shall be the primary payer of benefits throughout the entire thirty (30) month period and Covered charges payable under the Plan will not be reduced by any amounts payable under Medicare.

M. Medicare as Primary Payer
The following rules shall apply in the event Medicare is the primary payer of medical benefits for a Covered Person pursuant to applicable federal law:

1. Covered charges that would otherwise be payable under this Plan for any Health Care Services shall first be determined without regard to the amount of benefits payable under Medicare, and then reduced (but not below zero) by the amount of benefits payable under Medicare;
2. In the event a Covered Person incurs charges for Health Care Services from a Participating Medicare Provider or a Provider who is not a Participating Medicare Provider but is accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed the allowable charge under the fee schedule used by Medicare for such Provider or Participating Medicare Provider.
3. In the event a Covered Person incurs charges for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed 115% of the allowable charge under the fee schedule used by Medicare for such Provider or other applicable limit.

   In addition to the rights and authorities set forth herein, the Plan administrator reserves the right to use its discretion in determining which limit(s) is/are applicable charges incurred by a Covered Person for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting assignment-related basis.

N. Deemed Entitlement To Medicare
Any Covered Person who is an eligible retiree, or the spouse of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B Coverage for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medical Coverage.

O. Compliance With Medicare Secondary Payer Rules
This section shall be interpreted and administered in accordance with section 1862 of the Title XVIII of the Social Security Act and any regulation or other official guidance issued thereunder. In the event of a conflict between this Article IX and such statute, regulation or guidance, such statute, regulation or guidance shall govern.

ARTICLE X - GENERAL PROVISIONS

A. No statement by the Subscriber in his Enrollment Application shall void his Coverage hereunder or be used in legal proceedings hereunder unless such Enrollment Application or any exact copy thereof is included in or attached to his Member materials. All statements made by the Subscriber shall be deemed representations and not warranties.

B. All benefits payable hereunder shall be paid to the Provider of service rendering the service and billing for same. Indemnity in the form of cash will not be paid to any Covered Person except in reimbursement for payments made by the Covered Person to a Physician or other Provider of service for which the Covered Person has express Prior Authorization by the Plan, and for which the Plan was liable at the time of payment. As soon as practical, the person making claim for cash reimbursement for benefits provided under provisions in Article IV shall give to the Plan written proof of claim including full particulars of the nature and extent of the illness, injury or condition and treatment received and contemplated, and such other information as may assist the Plan in determining the amount due and payable. Proof of claims must be filed within one year of the date of service in order to receive payment.

C. No action at law or inequity shall be brought to recover on this Agreement or on any Subscriber certificate or Member materials issued pursuant hereto prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with requirements of this Agreement nor after ten (10) years from the expiration of the time within which proof of claim is required to be furnished under this Agreement or under any Subscriber certificate or Member materials issued pursuant hereto.

D. No interest in this Agreement nor in any materials issued pursuant hereto to Covered Person is assignable without written consent of the Plan being first obtained.

E. No person other than a Covered Person is entitled to any benefit listed in the Member materials issued pursuant to this Agreement. The Member materials, including but not limited to the Member handbook, benefit summaries and Membership Card shall not be transferable and shall be forfeited if any Covered Person attempts to transfer them, or aids or attempts to aid any other person in obtaining any benefits under them.

F. When applying for benefits or services under this Agreement, the Covered Person shall present the Membership Card provided by the Plan.

G. All required notices shall be in writing and shall be deemed sufficient if sent by U.S. Mail. Notices to a Covered Person may be sent to the last known address of such Covered Person or to such Covered Person in care of the Group. Notices given to the Plan shall be sent to the offices of the Plan. Notices given to the Group shall be sent to the last known address of the Group. All notices shall be effective at the time of posting.

H. The Group shall maintain records, satisfactory to the Plan, of the Subscribers and Covered Persons, showing with respect to each, information required in order to determine the existence of Coverage for any individual under this Agreement. The Group shall furnish on the Plan's forms such timely information relating to newly enrolled individuals, changes in classification, termination of Coverage and other changes relating to Subscribers and Covered Persons as may be required by the Plan to

administer the Coverage provided under this Agreement.

I. This Agreement shall be governed by and construed in accordance with the laws of the State of Indiana.

J. The relationship between the Plan and Participating Providers is that of an independent contractor. Hospitals, Physicians and other Participating Providers are not agents or employees of the Plan, nor is the Plan an employee or agent of the Participating Providers. Participating Providers shall maintain professional patient relationships with Members and are solely responsible to Members for all medical and Hospital services.

K. A Covered Person is responsible for presenting their insurance information to the provider at the time of service. Failure to do so within ninety (90) days will result in denial of claim for service.

ARTICLE XI - GRIEVANCE PROCEDURES

A. Grievance Resolution

If a Covered Person has a concern or question regarding the provision of Health Care Services or benefits under the policy, the Covered Person should contact M•Plan's Member Services Department at 1-800-816-7526 or write Member Services Department, M•Plan, 8802 North Meridian Street, Suite 100, Indianapolis, Indiana 46260-5371 as shown on his or her Membership Card.

The Covered Person has the right to appoint someone else, including their health care Provider, to represent the Covered Person in the complaint and appeals process, at the following address: Consumer Services Division, Indiana Department of Insurance, 311 West Washington Street, Suite 200, Indianapolis, Indiana 46202-2787 or by calling 317-232-2385.

B. Definitions

Grievance/Appeal – A dissatisfaction expressed orally or in writing by or on behalf of an enrollee regarding a denial of a covered service or the availability, delivery, appropriateness or quality of Health Care Services once proper carrier/eligibility information has been established. A request to change a previous decision made by the organization. A member, member representative or practitioner may appeal any adverse decision.

Pre-Service Grievance and Appeal – A request to change an adverse determination made by the organization for care or service that has not been provided to the member.

Post-Service Grievance and Appeal – A request to change an adverse determination made by the organization for care or service already rendered.

Urgent Care/Expedited Appeal – A request to change an adverse determination made by the organization for care or service that has not been provided or care and service that are actively ongoing and to which the application of the time periods for making pre-service or post-service appeal decisions could seriously jeopardize the life of health of the member or the ability of the member to regain maximum function if the care or service is not received.

C. Pre-Service Grievance/Appeal

1. When a Pre-Service Grievance/Appeal is received. A letter is sent to the Member within three (3) business days of receipt of the Grievance/Appeal. The letter:
   a. Acknowledges the receipt of the Member's Grievance/Appeal.
   b. Offers the Member the opportunity to be represented by someone of their choosing (including a practitioner or Member representative); and
   c. Advises the Member of the following options:
      i. Members may request to appear before the Appeal Panel;
      ii. Members may submit oral or written comments, documents, or other information;
      iii. Members who cannot appear in person at the hearing may communicate with the Appeal Panel via conference calling or other appropriate technology;
      iv. When a Member does not wish to participate in a hearing, the Appeal Panel will review the Appeal documentation and render a decision.

2. The Plan shall investigate the substance of the Grievance/Appeal including aspects of clinical care involved.

3. No Members of the Appeal Panel may be involved in any previous determination or are subordinates of any person involved in any previous determination.
   a. A Board Certified specialist of the same or similar specialty in Medical Necessity cases shall consult or participate in the appeal process when appropriate. This specialist shall:
      i. Have knowledge of the medical condition, procedures or treatment at issue;
      ii. Are in the same licensed profession as the Provider who proposed, refused or delivered the health care procedure, treatment or service;
      iii. Are not involved in the matter giving rise to the Appeal or the previous Grievance process; and
      iv. Do not have a direct business relationship with the Covered Person enrollee or the health care Provider who previously recommended the health care procedure, treatment or service giving rise to the Grievance.

4. The Grievance/Appeal will be completed and the Member notified of the decision within twenty (20) business days of the request. Notification includes:
   a. The decision, in clear terms, with the benefits or clinical rationale;
   b. A description of the next level of appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
   c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government.
   d. A list of titles and qualifications of individuals participating in the review of the Appeal;
   e. A statement of the pertinent facts of the appeal;
   f. A reference to the Group Service Agreement or contract provisions that support the decision;
   g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
   h. Statement of any additional information that could be helpful in the outcome of the appeal' and
   i. Instructions for requesting a written statement of clinical rationale and review criteria for cases involving a denial of medical services.

D. Urgent Care Appeal/Expedited Appeal

1. An Urgent Care Appeal/Expedited Appeal will be provided for requests for review of an adverse determination related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the Covered Person's:
   a. Life or health; or
   b. Ability to reach and maintain maximum function
   c. Requires medically necessary service within forty-eight (48) to seventy-two (72) hours.

2. Urgent Care Appeals may include Concurrent Care reviews as appropriate. Concurrent Care reviews concern an adverse determination of a request for benefits affecting an ongoing course of treatment taking place over a period of time or an adverse determination of a number of treatments.

3. Upon receipt of an Urgent Care Appeal from a Member or practitioner acting on behalf of the Member, the Plan shall:

a. Refer all documentation to a physician not involved in the initial decision who confers with appropriate specialists as indicated and make a decision on the Urgent Care Appeal/Expedited Appeal.
b. Notify the Member or practitioner verbally of the decision as expeditiously as the medical condition warrants, but no more than seventy-two (72) hours from the receipt of the Urgent Care Appeal/Expedited appeal;
c. Provide written confirmation of the Plan's decision to the Member and practitioner within two (2) business days of providing verbal notification of that decision.

4. Notification Letters are to include:

a. The decision, in clear terms, with the benefits or clinical rationale;
b. A description of the next level of Appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government;
d. A list of titles and qualifications of individuals participating in the review of the Appeal;
e. A statement of pertinent facts of the Appeal;
f. A reference to the Group Service Agreement or contract provisions that support the decision;
g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.

E. Post-Service Grievances and Appeals

1. Post-Service Grievance
At the time a Post-Service Grievance is received, the plan shall:
a. Notify the Member in writing within three (3) business days that his/her Post-Service Grievance has been received;
b. Provide the Member with information concerning the review process;
c. Submit the Post-Service Grievance to an individual not involved in any previous determination for a decision once all relevant information is gathered;
d. The grievance will be completed and the Member notified of the decision within twenty (20) business days of the request and appeal rights will be provided.

2. Post-Service Appeal
When a Post-Service appeal is requested by the Member:
a. A letter is sent to the Member from the Plan advising the Member that the review will proceed to the Appeal level. The letter shall:
i. Provide the Member with information concerning the Appeal process;
ii. Offers the Member the opportunity to be represented by someone of their choosing (including a practitioner or Member representative);
iii. Offer the Member the opportunity to stop the review process if they so desire;
iv. Advise the Member of the following options:
- Member may request to appear before the Appeal Panel;
- Members may submit oral or written comments, documents, or other information;

- Members who cannot appear in person at the hearing may communicate with the Appeal Panel via conference calling, video-conferencing or other appropriate technology.
- When a Member does not wish to attend a hearing the appropriate Appeal Panel will review the Appeal documentation and render a decision.

b. No Members of the Appeal Panel may be involved in any previous determination or be the subordinates of any person involved in the initial determination.
c. A Board Certified specialist of the same or similar specialty in Medical Necessity cases may be consulted or participate in the Appeal process when appropriate.
d. Letters to the Members of the Appeal decision shall include the following elements, when applicable:
   i. The decision, in clear terms, with the benefits or clinical rationale;
   ii. A description of the next level of Appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
   iii. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government;
   iv. A list of titles and qualifications of individuals participating in the review of the Appeal;
   v. A statement of the pertinent facts of the Appeal;
   vi. A reference to the Group Service Agreement or contract, provisions that support the decision;
   vii. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
   viii. Statement of any additional information that could be helpful in the outcome of the Appeal; and
   ix. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.
e. The Appeal review will be completed and the Member notified of the decisions no later than thirty (30) days from receipt of the Appeal.

F. External Review

Any Covered Person or his/her representative may file a written request for external review of a Grievance resolution decision with the Plan, at the aforementioned telephone number or address, no later than one hundred eighty (180) days after the Covered Person is notified of the Grievance resolution decision if it was a Grievance regarding:
1. An adverse utilization review determination;
2. An adverse determination of Medical Necessity; or
3. A determination that a proposed service is experimental or investigational (of a service proposed by the treating physician).

Resolution of an External Review must be completed within fifteen (15) business days after the Appeal is filed.

An Expedited Appeal will be provided for a Grievance related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the covered Person's:
1. Life or health; or
2. Ability to reach and maintain maximum function.

Resolution of an Expedited External Review must be completed within forty-eight (48) to seventy-two (72) hours after the Appeal is filed.

For Services received over twelve (12) months prior to the date of the grievance filing, the Member is responsible for obtaining all relevant information.

A Covered Person cannot file more than one (1) Appeal of the Plan's Grievance resolution decision. All Costs will be paid by the Plan. The Plan shall provide a procedure for reconsideration if new evidence for consideration is submitted to the Plan during the External Review process. The decision of the External Reviewer shall be binding on the Plan but not on the Covered Person. If the Covered Person has the right to an external review under Medicare, the Covered Person may not request an External Review under this process.